HEALTH CARE FRAUD AND WASTE
(Part 2)

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

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ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

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HEALTH CARE FRAUD AND WASTE

WEDNESDAY, MARCH 18, 1992

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 11 a.m., in room 2123, Rayburn House Office Building, Hon. John D. Dingell (chairman) presiding.

Mr. DINGELL. The subcommittee will come to order.

Over the past year, the subcommittee has held numerous hearings dealing with fraud, waste, abuse in the health care industry. Witnesses from the Federal Bureau of Investigation told the subcommittee that physicians, hospitals, pharmaceutical companies, and patients themselves were all too often engaging in out-and-out fraud. Some of the experts have warned that between $50 and $80 billion per year is squandered on these wasteful and fraudulent schemes.

The subcommittee has also heard testimony about exorbitant patient charges for medical supplies at Humana Hospitals. These outrageous charges were exemplified by Humana's $143.35 patient charge for a crutch, when Humana only paid $9.66 for it. Since the Humana hearing, the subcommittee has expanded its health care investigations into hospital closures, as well as Medicare overbillings and overcharges by hospitals.

We have heard that low Medicare reimbursement rates are causing many of the Nation's hospitals to close their doors. We want to know whether this in fact is true. The subcommittee will hear today that this is largely myth, and to the contrary, that there are numerous market-based reasons for the closings.

Furthermore, the inspector general of the Department of Health and Human Services will testify today that hospital closures have not reduced patients' access and care, nor subjected them to poorer quality of care.

We will hear today that hospitals throughout the country were sitting on bulging slush funds. The inspector general estimates at least $265 million in Medicare double billings and overbillings are in the coffers of the hospitals.

Even this quarter of a billion dollar figure may be significantly understated, because the inspector general's analysis looked at a statistical sampling of only 20 percent of the Nation's hospitals, specifically those with more than 200 beds, and whose bills were paid by 9 of the 56 intermediaries under contract with the Health Care Financing Administration.

Some hospitals apparently just simply pocketed these Medicare moneys with little more than a stroke of the pen, when regulation and propriety demanded their return to the taxpayer.

The subcommittee intends to pursue these serious charges to determine the extent of this possible fraud and who is responsible. We also intend that these matters will come to a sharp and sudden halt.

Hospitals, however, are not solely to blame. The Health Care Financing Administration [HCFA] and its intermediaries knew far too little about which hospitals owe Medicare money and how much they owe. In a rather bizarre turn of events, it appears that some intermediaries have not accepted checks from hospitals when the hospitals themselves identified overpayments. It is a most curious event. Despite being aware of the problem, HCFA has had considerable difficulty in eliminating the problem.

For example, HCFA has even encouraged its intermediaries to develop new computer systems to save money, but surprisingly, they failed to set any minimum requirements for what the systems should do. Not only have they neglected to evaluate the effectiveness of existing systems, the agency provided no oversight while the new systems were being built. Consequently, efforts to achieve savings in administrative costs and better oversight of what Medicare pays for have actually resulted in more overbilling, more errors, and higher administrative costs.

There is yet another instance of seemingly inexplicable behavior on the part of the Federal Government. HCFA did start a new program to require hospitals to submit quarterly reports showing Medicare overcharges, only to be stopped by the Office of Management and Budget. Following complaints from some hospital administrators, the OMB claimed that HCFA was violating the Paperwork Reduction Act. The OMB directed HCFA to suspend the reporting requirement, ignoring the fact that HCFA had recouped $66 million owed to Medicare as a result of the new program. So perhaps we will want to hear from OMB on this matter.

All of the issues before us today raise serious questions about the magnitude of the overbilling problem, whether HCFA will be able to identify and recover overpayments, and whether the administration is truly interested in recouping huge amounts of taxpayers' money owed back to Medicare.

We also expect to learn about the true causes of hospital closings and their impact on patient care.

And finally, because of the implications of these issues for health care cost containment, the Chair looks forward to the testimony on what he believes should be done to hold down health care costs.

The Chair wants to make a couple of other observations that I think are important.

We have sought on this committee to be supportive of health care programs and of hospitals and health care providers. We have sought to see to it that they are fairly treated. We have sought to see to it that they are properly compensated. We have resisted strongly the efforts of the administration to cut unwisely, unnecessarily, and imprudently the payments to hospitals, nursing homes, and other health care providers.

It would be regrettable, however, if we could not deal with them fairly in terms of seeing to it that their payments are proper and adequate, but also in seeing to it that there are no charges which are excessive, improper, or improperly audited.

We believe what is fair for the taxpayer is that the health care provider should be paid properly. That does not mean too much, too little, or in excess of what the law permits or requires. Nor does it mean less than what they should receive as a matter of good conscience.

We find ourselves surprised on this subcommittee by the lack of proper supervision of government contractors, colleges, universities, defense contractors, EPA contractors, and now hospitals. We have seen massive proliferation of suppliers of different kinds and innovative devices manufacturers ripping off the taxpayers. We intend to try to bring those matters to a halt and we will be pursuing this matter.

I will recognize my good friend from Virginia, Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman. I commend you for calling this hearing into the financial institutions' viability.

Five months ago we heard about the amount of the hospital pricing policies, which meant routinely overcharging on ancillary items, bedpans, saline solutions, and crutches.

Room rates were artificial and attractively low. This is done for competitive reasons. Room rates are the most visible aspect of a hospital's pricing, and as such they come under a great deal of scrutiny not only by HCFA, but by patients.

Therefore, in order to meet preset revenue goals, they simply overcharge for ancillary items. Many times they are marked up many times over the item. This is done for a major profit for a hospital.

We were assured by the chairman and other witnesses that Humana is not alone in pricing. Indeed we were assured Humana was only following the practice of the industry in general, both for-profit and nonprofit. This "everybody is doing it" argument, while possibly criticism, to the industry in general was cold comfort at best.

Today's hearing will look at the industry in general, and while we will not be examining the specific issues we looked at in October, we will be looking at the related issues of credit balance, double billing, and other bookkeeping methods employed by the hospital industry.

We will also look at an attempt by HCFA to rein in automation costs, and examine whether the effort has lowered costs or has even increased them.

I look forward to today's testimony in working with you, Mr. Chairman, to learn more about hospital pricing practices and what can be done to improve them. Thank you very much.

[The prepared statement of Hon. Thomas J. Bliley, Jr., follows:]

STATEMENT OF HON. THOMAS J. BLILEY, JR.

Thank you, Mr. Chairman. I commend you for calling this hearing to continue this subcommittee's examination of the hospital industry's financial practices and viability.

Five months ago we heard about Humana Hospital's pricing policies, which amount essentially to routinely overcharging on so-called ancillary items like bedpans, crutches, and saline solution, while at the same time keeping hospital room rates artificially and attractively low. This is done, we were told, for competitive reasons. Room rates are the most visible aspect of a hospital's pricing, and as such they come under a great deal of scrutiny not only by HCFA, but also by patients. Therefore, in order to meet its preset revenue goals, Humana simply overcharges for ancillary items—sometimes at markups of many times the actual price of the item.

That this is done by a major for-profit hospital came as somewhat of a shock. However, we were assured by Humana's chairman and other witnesses that Humana is not alone in its pricing endeavors. Indeed, we were assured that Humana was only following the practice of the industry in general, both for-profit and nonprofit. This "everybody's doing it" argument, while possibly helping to deflect some of the criticism off Humana directly and diffuse it to the industry in general, was cold comfort at best.

Today's hearing will look at the industry in general, and while we will not be examining the specific issues we looked at in October, we will be looking at the related issues of credit balances, double billing, and other bookkeeping methods employed by the hospital industry. We will also look at an attempt by HCFA to rein in automation costs in connection with Medicare billings nationwide, and examine whether the effort has in fact lowered costs or has even increased them.

I look forward to today's testimony, and to working with you, Mr. Chairman, to learn more about hospital pricing practices and what can be done to improve them.

Thank you.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair advises that our first witness is Mr. Richard P. Kusserow, inspector general of the Health and Human Services.

The committee welcomes you back. You have provided good service, good advice, and vigorous investigative activities inside the agency. You have assisted the committee in most significant ways in seeing that abuses are brought to a halt and wrongdoing comes to light. We are appreciative of your prior service and grateful you will be with us today.

It is the practice of the committee that all persons appear under oath. Do you have any objection?

Mr. KUSSEROW. No.

Mr. DINGELL. It is your right to be advised by counsel during your appearance.

Mr. KUSSEROW. No.

Mr. DINGELL. Copies of the rules of the House, subcommittee, and the committee are there at the committee table before you, to advise you of your rights and limitations on the part of the committee.

If you will please raise your right hand.

[Witness sworn.]

Mr. DINGELL. You may consider yourself under oath. We will be happy to recognize you for whatever statements you choose to give.

Mr. KUSSEROW. Thank you, Mr. Chairman. If I could, let me highlight from my prepared testimony.

Mr. DINGELL. Your full statement will be inserted. We will recognize you as such summaries you wish to give.

Mr. KUSSEROW. As you and Mr. Bliley introduced at the beginning of the hearing, the subcommittee had come to us and said that basically the concerns were being brought to the subcommittee——

Mr. BLILEY. Would you turn the microphone on, please.

Mr. DINGELL. You will find, Mr. Kusserow, on this visit, as on prior visits, we have the worst public address system in Washington. Be close to the mike.

TESTIMONY OF RICHARD P. KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KUSSEROW. Thank you, Mr. Chairman.

As the opening remarks pointed out, there was considerable concern raised to the subcommittee that hospitals were operating under distress circumstances, and a significant portion of those distress circumstances financially go back to the Health Care Financing Program, Medicare part A, and this was of great concern when it came time for updating the payments under the prospective payment system.

As Mr. Bliley pointed out in his comments, there is a desire for the subcommittee to focus on practices and viability. The first step in that process was to report to the subcommittee on hospital closures. That's what we intend to do. We have looked at hospital closures now for the last 5 years and we give some insights on that.

The second phase of our testimony relates to the issue of credit balances; that is, do hospitals maintain excess credit balances owed back to Medicare?

With regard to the question of closure of hospitals, we have, in fact almost from the very date that Dr. Sullivan reported on his request, been tracking every hospital closing in the United States. We have reports on these closures which we have made available to the subcommittee.

Just what we are finding is that the pattern has remained fairly constant. In all of our reports, we have not made any recommendations. These are just findings. We are tracking what is out there, and leaving it up to policymakers to make determinations as to what might be appropriate.

The most significant finding we have had over the last 4 years, and included in our most recent report, is that hospitals do close. This last year that we reported on, there were 56 hospitals which did close, which represents 1 percent of the hospitals in the country. This is 20 fewer than the previous year. The closures can be split pretty evenly between urban and rural and across 26 States.

It should be noted that also there were seven new hospitals that did open during the same period of time, and also there were two hospitals that reopened from the previous period.

The closed hospitals, regardless of the setting, had some characteristics that were in common. They tended to be very much smaller and had lower occupancy rates than those others operating in and about the same area and nationally.

More specifically, closed rural hospitals were about 39 beds in size versus 83 beds for the average of rural hospitals nationwide. That translates to nine patients versus an average of 39 percent of the hospitals in the aggregate. The closed urban hospitals averaged 93 beds versus urban 245 nationwide.

Though 1 percent of the hospitals closed because of the fact they were smaller hospitals, they represented less than one-half percent of the beds in the United States.

It should also be noted that occupancy rates are about 60 percent. So about 40 percent of the beds are unoccupied. We continue to have an excess bed capacity in the United States.

As to the reasons why hospitals closed in 1990, they are virtually the same as in previous years and they are interrelated. They have declining patient occupancy, which in turn leads to rising cost per patient, which makes it financially not viable to continue.

The fact of the matter is, if you were to look at the patient census of Medicare beneficiaries, you would see there are not enough patients in the hospitals. Regardless of what rate they were reimbursed, Medicare payments could have kept the hospitals going. There is no evidence to suggest that the Medicare or Medicaid patients and the payments for services to support them was the approximate cause of any of these closings.

The chief cause, if you want to come down to it of why hospitals close, is physicians. Physicians decide for the good of their patient that it is better to move them down the road to a larger hospital which has a full range of services rather than in the hospital that might be in the community.

It is logical to point out that if you had a 20-bed hospital in a community and if dad had a heart attack, and you had a choice of going to that 20-bed hospital or going down the road for 15 or 20 minutes in an ambulance to a hospital that had a care center, the logical medical step would be for the physician to get that patient to the larger hospital to make sure the patient has care.

The crucial question for our Department was the concern about beneficiaries: Do they have access to care? In other words, when the hospitals close, does it mean they do not have access to acute care? What we found in all of our reports is the emergency and inpatient medical care continues to be available within 20 miles in the vast majority of the communities.

Further, the physical facilities of 31 of the 56 closed hospitals we observed in this last year continue to be used within the community for health care related purposes. In addition, we noted that plans are underway at another eight institutions which are being worked on to be converted to other health purposes.

The second issue of credit balances, which was alluded to in the opening statements by you, Mr. Chairman, and by you, Mr. Bliley, is an old question for us. In fiscal year 1986, we had completed an examination very similar to what we are reporting on today, wherein we found there was a projected $164 million in credit balances owed to Medicare nationwide. At the time we issued that report, HCFA agreed with our findings and took steps to collect those, and we recovered them. They instituted procedures to deal with these balances.

The frustrating thing for us, I am loath to admit, is that the problem still exists; it is still there and there is reason for it. The fact is that during the periods that followed the issuance of that report and the initial collection of the overpayments, the budget for the fiscal intermediaries that dealt with the collection, that would have responsibility for the collection, was cut, and they maintained their resource in the high priority areas and relegated their excess credited balances to secondary status. I am talking

about another quarter of a billion dollars, and we need to take additional steps to straighten out this mess.

As you noted in the opening remarks, we focused really on hospitals that had 200 beds or more, and took a stratified sample of those hospitals. The question we were asked by staff is what would it take to look at all the hospitals and not just the sample. We would estimate it would take 2½ million staff hours to do that, which is twice the number of auditors we have. That would be a very formidable task.

Our current review was to find out if credit balances were accruing and what was the cause. We found in that quarter of a billion dollars there were several reasons.

The largest portion, about half, $123 million in overpayments, resulted from hospitals billing Medicare and a private insurer for the same service, and then being reimbursed by both. Medicare is a secondary payer, and it was not paid back.

The second largest cause of overpayments, $100 million, was caused by hospital errors that result in rebillings for the same service which resulted in double payments.

Another $20 million of overpayments were caused by billing for services planned and not performed, and a failure to reconcile.

Another $13 million of overpayments were caused by miscellaneous errors for the most part by intermediaries reflecting control failure. We found errors in calculating the deductible and coinsurance amounts for covered services.

We also had other miscellaneous problems, which I laid out in our testimony in the reports that again shows that a lot of it is sloppy bookkeeping and failure to reconcile.

I think the key question comes down to why, once these things have been identified, once the hospitals know they have excess credit balances, why don't they refund Medicare for it?

No. 1, I think one thing unstated, since there is no penalty for retaining the excess credit balances, if you intend to pay it later on, you get a benefit of the interest flow on it. There is no incentive to pay it right away. It is, in fact, free money until you have to pay it. Maybe you never have to pay it.

The most disturbing thing we found was that two-thirds of the hospitals, 53 of the 76, attempt to some degree to repay Medicare overpayments. How forthcoming it was—they did flag the intermediaries and tell them of excess credit balances and wanted to repay it. The fiscal intermediaries did not make that possible. It was too low a priority and they did not.

So you are quite right in saying you wanted to find the culprits. You certainly can have many culprits, but two-thirds did try to make payments. Maybe it is my Presbyterian ways, but if a check is owed to you, you accept it.

We have made available to the committee all 76 of the individual reports of the hospitals, and I will be pleased to talk about any of those if you like. We also have still underway—we want to issue separate reports of the intermediaries that we have found problems with, and try to bring them into compliance and to ensure that hospitals are in compliance with Federal laws and regulations. This really requires that they have to strengthen their controls

over credit balances. We will also be asking HCFA to review the performance of the intermediaries in light of our findings.

Suffice it to say, as we have gone through the 76 individual audits; we wanted to run them through a review, and that review really relates to the issue of whether there was a willfulness on the part of hospitals of not paying back the money.

So our investigation has been screening through to see if there is any evidence of planned diversion of that money, and thus far 57 of the 76 audits have been cleared. We still have 19 we are looking at. It is possible we may have out of them some that may require some sort of action in the legal arena to bring them into compliance with the Federal law.

With regard to the intermediaries, we are certainly recommending HCFA review the Medicare accounts. One of the things that bothered us is that we pay about $58 million to the fiscal intermediaries to do field audit work. The oversight of hospitals under part A was disturbing; it was such a low priority. When they do the field reviews, they don't look at the credit balances. We think they should look at them.

We think HCFA needs to review the intermediaries' compliance with the credit balance requirements during its annual evaluation of the intermediaries.

So far, virtually all of the reports we have issued, going back to the fiscal year 1986 report, have been strongly supported and endorsed by HCFA. They are acting upon the work that we have done thus far, and as pointed out in the chairman's opening remarks, we are getting back about $10 million a month from the work that we have done so far.

I wanted to recheck the numbers. The $66 million in recoveries thus far—as of yesterday, HCFA now has been paid $84 million, so we are beginning to get money back from this process.

The specific recommendation to HCFA for their own internal use: We feel they need to continue their pursuit of recoveries by requiring hospitals to report Medicare credit balances to intermediaries on a quarterly basis; require them to respond timely to any attempts by hospitals to refund Medicare overpayments; and also require intermediaries to include in their hospital audits a review of all Medicare credit balances.

I would add a couple of other things, Mr. Chairman. One of the things that I think must inherently be there is from the time that money is owed to Medicare, it seems to me they should not have the benefit of that money interest free. As almost in any situation, where money is paid back to trust funds or to Uncle Sam, interest should accrue from the first day calculated at the prime intent note plus one, or some other formula, so there is little incentive to keep the money.

I believe work should be done to try to encourage or find or mandate or cause the hospitals to include this element in their financial statements that is subject to the audits that are performed by independent public accounting firms, so that we can in fact be able to see at any given time whether there are excess credit balances, and if they are moving from one category to another, that it is somehow reflected in the audit of the financial statement.

I will conclude on that note, Mr. Chairman, and say only that HCFA has been very supportive on the work we have done so far. It is frustrating to have a lot of support by the Health Care Financial Administration going back to 1986, and still have this problem.

I think that it is very useful for the subcommittee to be holding this hearing to put some sunshine on this problem and help us to eliminate it once and for all.

Thank you.

[Testimony resumes on p. 48.]

[The prepared statement and attachments of Mr. Kusserow follow:]

STATEMENT OF RICHARD P. KUSSEROW

Good morning, I am Richard P. Kusserow, Inspector General of the Department of Health and Human Services. I am here today to discuss how hospitals are faring under Medicare. Our testimony covers two general areas. First, we will address the report on our examination of hospital closures for the past four years to provide insights as to the proximate causes for those closures. In addition, we have been asked by the Subcommittee to specifically address the impact on patient access in those communities where hospitals have closed. The second general area of testimony will focus on our nationwide review of Medicare credit balances reported on hospitals' accounting records. We have focused on the amount of overpayments that is owed by hospitals to Medicare. For both of these issue areas, we are submitting to the Subcommittee a full report of the details of our findings.

I. HOSPITAL CLOSURES

The first issue I would like to discuss deals with hospital closures. The Subcommittee expressed concerns as to the extent and causes of hospital closures. In particular, we were requested to address the question as to whether Medicare payments were a significant cause of the closures and what effect they were having on patient access to care.

Dr. Louis W. Sullivan, expressed a similar concern upon his arrival as Secretary of the Department of Health and Human

Services. He requested that we track all hospital closures in the United States to identify their causes and effects in limiting access to hospital care. We have done this for the past 4 years. The short answers to the key questions are that Medicare is not causing the closures and there is no significant impact on beneficiary access to inpatient and emergency room services.

Our January 31, 1992 report produced findings similar to those reported in previous years. Among the most significant specific findings were:

- 56 general, acute care hospitals (approximately 1 percent of total) closed. This was 20 fewer closings than the previous year. The closures were split evenly between urban and rural hospitals and were spread across 26 states. However, it should be noted that seven new hospitals opened during the same period plus two hospitals that had closed in the previously reported period had reopened.

- Closed hospitals, regardless of setting, were much smaller and had much lower occupancy rates than the national averages. More specifically, closed rural hospitals were, on average, about 39 beds in size versus about 83 beds for the average of rural hospitals

nationwide. Their occupancy rates averaged about 24 percent, which equals about 9 patients, versus an average of 39 percent for rural hospitals nationwide. Closed urban hospitals averaged 93 beds versus the urban average of 245 beds. Occupancy rates for the closed urban hospitals averaged 30 percent or 28 patients; in contrast all urban hospitals averaged nearly 57 percent. Though one percent of the hospitals closed, they only represented less than 1/2 percent of the beds.

- The reasons for hospital closures in 1990 were virtually the same as the interrelated factors reported in previous years; namely, declining patient occupancy, resultant lagging revenues, which in turn led to rising costs per patient. No hospital can remain viable without stability on all three factors. There were no indications that Medicare was the controlling factor in any of the closures.

- Insufficient payments for Medicare and Medicaid patients were not the cause of any of these closings. Although these patients had represented over half the patient census, their numbers were not sufficient to support the infrastructure cost of the institution. The short answer to why hospitals closed is that

doctors stopped referring patients to those institutions and sent them elsewhere. The average daily number of Medicare beneficiaries in rural hospitals was 4.4 and in urban hospitals it was 14.4.

- Access to hospitals for beneficiaries of Medicare and Medicaid is not a significant problem in those communities where hospitals closed. Emergency and inpatient medical care continues to be available within 20 miles of most of these communities. Further, the physical facilities of 31 of the 56 closed hospitals continue to be used in the community for health related purposes. In addition, plans are underway at 8 of the remaining 25 closed hospitals to open the facilities to provide health-related services to the community.

II. CREDIT BALANCES OWED TO MEDICARE

The second issue that I would like to discuss today is our nationwide review of hospital Medicare credit balances. Early in Fiscal Year 1986, we projected $164 million in credit balances nationwide, based on a review of 50 hospitals in 5 States. While the Health Care Financing Administration (HCFA) collected those overpayments, and took some steps to institute procedures to deal with these balances, the problem still exists. Our current review at 76 hospitals and 9 intermediaries shows that additional

Medicare credit balances have occurred and amount to an estimated $265.9 million and that HCFA must take additional steps to ensure that Medicare overpayments are refunded to the intermediaries.

The primary objective of our current review was to determine if hospitals were reviewing Medicare credit balance accounts to identify Medicare overpayments and refunding the overpayments to their intermediary as required by law. We identified several reasons for these credit balances, and most of them were attributable to poor hospital accounting practices.

- $123 million in overpayments, or 46.3 percent of the total, resulted from hospitals billing Medicare and a private insurer for the same service, being reimbursed by both, and keeping both payments. The provisions of the Medicare Secondary Payer program state that Medicare will not reimburse for services if the services are covered by another insurer. The hospitals set up a Medicare credit balance for the excess reimbursement, but we found they did not always review the balances to determine their cause and whether a Medicare overpayment existed.

- $96.6 million in overpayments, or 36.3 percent, were caused by hospital errors that resulted in submitting rebillings for the same services, resulting in double

payments. This evidences a weakness in the hospitals' internal control system. Of equal significance was that most of the overpayments also went undetected by intermediaries which are funded by HCFA to review the cost reports and ensure proper reconciliation. Their failure to detect these overpayments was due to a variety of reasons, including hospitals using and confusing different procedure codes, or dates of service for the same service. The fact that they were not detected by the field reviews strongly suggests intermediaries are not reviewing credit balance accounts. Its just been too low a priority for them to do so.

- $19.4 million of overpayments, or 7.3 percent, were caused by hospitals billing for services planned but ultimately not performed. When the hospitals became aware that the services were not performed, they canceled the charges, thus creating a Medicare credit balance. Unfortunately, the final step was not often taken by the hospitals, that is, to refund the overpayments.

- $12.7 million of overpayments, or 4.8 percent, were caused by miscellaneous errors made for the most part by intermediaries, reflecting another internal control

failure. For example, we found errors in calculating the deductibles and co-insurance amount, and payments made for non-covered services.

- $4.8 million of overpayments, or 1.8 percent, were caused by the hospitals inappropriately billing for outpatient services that were included in a beneficiary's inpatient claim. Medicare regulations require that any outpatient service performed within a certain number of hours prior to admission is to be included as part of the inpatient service.

- The balance of $9.4 million in overpayments, or 3.5 percent, are various other errors projected but not adequately defined to be properly allocated to one of the other categories.

In as much as hospitals established Medicare credit balances on their accounting records, the key question is why did they not take the next step to research these balances and refund any Medicare overpayment to the intermediary. We found that, for the most part, hospitals did not review the credit balances to determine if they resulted from accounting errors or Medicare overpayments.

We also found, somewhat surprisingly, that intermediaries were not always recovering overpayments even when hospitals attempted to return them. We found that 53 of the 76 hospitals included in our review attempted unsuccessfully to repay some Medicare overpayments to their intermediary. Although we have not completed this portion of our review, evidence suggests that intermediaries give priority to making payments, with recovery of overpayments getting secondary attention leading to the current problem.

We have issued individual reports to the 76 hospitals that we have audited. We have directed our findings on improvements of internal controls to identify receipt of overpayments and, equally important, to refund all of the overpayments owed to Medicare. The hospitals have generally not contested our findings and have agreed with our recommendations, including full restitution to Medicare.

We also intend to issue separate audit reports to the fiscal intermediaries charged with auditing and ensuring the cost reports are accurate and in compliance with federal laws and regulations. We will be recommending that they strengthen their internal controls over Medicare credit balances. We will also be asking HCFA to review the performance of the intermediaries in light of our findings.

Our Office of Investigations is in the process of reviewing the results of all 76 audits for indications that some of the duplicate billings and subsequent failures to reconcile were designed or fraudulent. We are particularly interested in hospitals that submitted duplicate claims and kept both payments without attempting to refund the Medicare overpayments to their intermediary. Thus far we have determined that 57 hospitals did not have billing practices suggestive of a willful desire to defraud Medicare. The remaining 19 hospitals are still undergoing further review. We will be pleased to report back to the Subcommittee the final results of this part of our review.

On August 29, 1991, we issued a management advisory report to HCFA alerting it to our findings on credit balances. We reported that hospitals were not reviewing Medicare credit balances to identify Medicare overpayments for refund to the intermediary. We recommended that HCFA: (1) require intermediaries to review Medicare credit balance accounts during their hospital audits; and (2) review the intermediaries' compliance with this requirement during its annual evaluation of intermediary operations.

The HCFA response to our report was overwhelmingly positive and supportive. Not only did HCFA agree with both of our recommendations, but action was taken to recover Medicare overpayments from providers. The HCFA instructed the

intermediaries to contact all providers and require them to report Medicare credit balances on a quarterly basis. To date this action resulted in recoveries of over $66 million in Medicare overpayments. This has confirmed the results of our earlier efforts and validates our current effort to repair this major program vulnerability.

The report we are releasing today is undergoing review and comment with HCFA. Our projections of Medicare overpayments owed by hospitals is estimated currently at $265.9 million less the amount recovered by HCFA as a result of their earlier actions on our first report. This is a clear indication that HCFA would benefit by continuing its pursuit of recoveries for the balance of at least $200 million. We also point out two recent developments not included in the original report. One issue deals with the failure of intermediaries in recovering overpayments reported to them by hospitals. The other issue deals with some hospitals writing off Medicare credit balance accounts without refunding the Medicare overpayments to their intermediary, which is a gross violation of accounting procedures at best.

Our specific recommendations to HCFA are: (1) to continue its pursuit of recoveries by requiring hospitals to report Medicare credit balances to intermediaries on a quarterly basis; (2) require intermediaries to respond timely to any attempts by

hospitals to refund Medicare overpayments; and (3) require intermediaries to include in their hospital audits a review of all Medicare credit balance accounts written off by hospitals so that Medicare overpayments in these accounts can be refunded to the program.

In view of HCFA's continued interest and support on this issue, we are confident that: (1) the Medicare overpayments owed by the hospitals will be recovered; (2) controls will be strengthened at the intermediaries; and (3) there will be a significantly lessening of the problem of Medicare overpayments not being refunded to the intermediaries.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you may have.

SUMMARY OF MEDICARE CREDIT BALANCE REVIEW

HOSPITAL	PROJECTED TOTAL FINDINGS	PROJECTION
Region 1		
Blue Cross and Blue Shield Of Connecticut <00060>		
1. Yale New Haven Hospital	$364,333	
2. Norwalk Hospital	$386,857	
3. Danbury Hospital	$81,565	
4. St. Vincent's Medical Center	$36,069	
5. Greenwich Hospital Association	$84,066	
6. St. Mary's Hospital	$31,540	
7. Stanford Hospital	$529,966	
8. Griffin Hospital	$175,144	
Summary Region 1	$1,689,540	$3,167,886
Region 2		
Blue Cross and Blue Shield of New Jersey <00280>		
1 Atlantic City Hospital	$94,622	
2. Overlook Hospital	$151,040	
3. Christ Hospital	$139,008	
4. United Hospital Of Nowark	$76,521	
5. St. Clair Riverside Medical Center	$30,228	
6. Our Lady Of Lourdes Medical Center	$246,656	
7. Kimball Medical Center	$700,178	
8. Medical Center At Princeton	$103,719	
Summary Region 2	$1,541,972	$15,034,230

SUMMARY OF MEDICARE CREDIT BALANCE REVIEW

HOSPITAL	PROJECTED TOTAL FINDINGS	PROJECTION
Region 3		
Blue Cross and Blue Shield of Maryland <00190>		
1. Johns Hopkins Hospital	$578,012	
2. Washington Hospital Center	$227,465	
3. Harbor Hospital Center	$284,024	
4. Suburban Hospital Association	$36,432	
5. Anne Arundel General Hospital	$8,170	
6. Washington County Hospital	$63,593	
7. Liberty Medical Center	$162,085	
8. Frederick Memorial Hospital	$62,835	
9. Georgetown University Hospital	$5,104	
	$1,427,720	$6,940,357
Independence Blue Cross		
1. Saint Joseph's Hospital	$0	
2. Saint Agnes Med. Ctr.	$0	
3. Albert Einstein Med. Ctr.	$231,283	
4. Temple University Hospital	$64,204	
5. Magee Rehab. Hospital	$8,059	
6. Eagleville Hospital	$0	
7. Lawndale Community Hospital	$1,174	
8. Warminister Hospital	$244	
9. North Penn Hospital	$14,096	
10. Delaware Valley Mem. Hospital	$2,053	
11. Southern Chester Hospital	$3,422	
Summary Region 3	$324,535	$1,249,179

SUMMARY OF MEDICARE CREDIT BALANCE REVIEW

HOSPITAL	PROJECTED TOTAL FINDINGS	PROJECTION
Region 4		
Blue Cross and Blue Shield of South Carolina <00380>		
1. Spartanburg Regional Medical Center	$15,568	
2. Baptist Medical Center At Columbia	$294,847	
3. Roper Hospital	$54,294	
4. McLeod Regional Medical Center	$40,081	
5. St. Francis Xavier Hospital	$70,578	
6. Trident Regional Medical Center	$84,519	
7. Lexington Medical Center	$34,912	
8. Tuomey Regional Medical Center	$26,826	
Summary Region 4	$621,625	$1,320,952
Region 5		
Blue Cross and Blue Shield of Wisconsin <00450>		
1. Meriter Hospital	$36,958	
2. St. Francis Hospital	$245	
3. Sinai Samaritan Hospital	$146,142	
4. Trinity Memorial Hospital	$19,732	
5. Sacred Heart Hospital	$28,046	
6. St. Catherines Hospital	$40,307	
7. St Lukes Hospital	$32,858	
8. St. Joseph's Hospital	$10,805	
Summary Region 5	$315,093	$1,339,146

SUMMARY OF MEDICARE CREDIT BALANCE REVIEW

HOSPITAL	PROJECTED TOTAL FINDINGS	PROJECTION
Region 5		
Blue Cross and Blue Shield of Michigan <00210>		
1. Henry Ford Hospital	$290,226	
2. Sparrow Hospital	$149,457	
3. Providence Hospital	$243,178	
4. St. Joseph's Hospital	$144,231	
5. Marquette General Hospital	$57,070	
6. Ingram Medical Center	$13,155	
7. Hutzel Hospital	$168,791	
8. Crittenton Hospital	$37,929	
Summary Region 5	$1,104,037	$7,728,253
Region 6		
Blue Cross and Blue Shield of Oklahoma <00340>		
1. St Francis Hospital	$191,684	
2. Baptist Medical Center Of Oklahoma	$38,979	
3. South Community Hospital	$8,542	
4 Mercy Health Center	$7,880	
5. Oklahoma Osteopathic Hospital	$70,329	
6. Muskogee Regional Medical Center	$10,385	
7. Jane Phillips Memorial Medical Center	$9,870	
8. Deaconess Hospital	$2,990	
Summary Region 6	$340,659	$681,318

SUMMARY OF MEDICARE CREDIT BALANCE REVIEW

HOSPITAL	PROJECTED TOTAL FINDINGS	PROJECTION
Region 9		
Blue Cross of California <00040>		
1. University Of California San Francisco	$110,496	
2. St. John's Hospital and Health Center	$130,189	
3. University of California At San Diego	$63,436	
4. Tri-City Hospital Medical Center	$473,936	
5. Little Company of Mary Hospital	$256,215	
6. Northridge Hospital And Medical Center	$347	
7. Mission Hospital Regional Med. Center	$136,428	
8. Peralta Hospital	$108,626	
Summary Region 9	$1,279,673	$18,075,381
Grand Total		$55,536,702
Total National Projection		$265,900,854

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Memorandum

Date

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From Richard P. Kusserow
Inspector General

Subject Update on Findings Developed in Our National Review of Medicare Accounts Receivable With Credit Balances (A-03-92-00010)

To J. Michael Hudson
Acting Administrator
Health Care Financing Administration

This draft Office of Inspector General (OIG) management advisory report (MAR) is to provide you an update on our findings being developed in the national review of Medicare accounts receivable with credit balances (hereafter referred to as Medicare credit balance accounts) at 76 hospitals and 9 intermediaries.

On August 29, 1991, we issued a MAR to the Health Care Financing Administration (HCFA) on the preliminary results of our pilot review of Medicare credit balance accounts at 11 hospitals served by 1 intermediary. We concluded that 8 of the 11 hospitals were not reviewing all of their Medicare credit balance accounts to determine if they had received Medicare overpayments. Instead, the eight hospitals kept the Medicare overpayments and the intermediary (Independence Blue Cross) failed to detect the error.

We recommended that HCFA: (1) require intermediaries to review Medicare outpatient credit balance accounts during hospital audits and (2) review intermediaries' compliance with the audit requirement. We also reported that, as a result of this pilot study, we had expanded our review nationally to additional hospitals and intermediaries.

The HCFA response to our prior MAR was very favorable. The HCFA agreed to implement our recommendations, and also instructed all intermediaries to require hospitals to report their Medicare credit balances on a quarterly basis. To date, HCFA's actions have resulted in recoveries of Medicare overpayments totaling about $66 million.

HCFA agreed with OIG's recommendations and implemented a plan of recovery which, to date, has resulted in recoveries of about $66 million. Newly developed findings require additional action on the part of HCFA.

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Our preliminary results at the 76 hospitals and 9 intermediaries show that the conditions reported in our initial MAR are national in scope. Based on statistical sampling techniques, we estimate that hospitals owed the Medicare program about $265.9 million, or about $200 million more than currently recovered by the intermediaries.

Furthermore, we have identified two findings that were not addressed in our previous MAR to HCFA. First, the intermediaries did not always respond to attempts made by hospitals to refund Medicare overpayments to the program. Second, at least five hospitals wrote off Medicare credit balance accounts without refunding Medicare overpayments to the intermediaries.

The recommendations in our previous MAR, to which HCFA responded quickly and effectively, did not specifically address the new issues brought to light in this report. We, therefore, believe that HCFA needs to continue its recovery efforts and to supplement its instructions to the intermediaries by requiring them to: (1) respond timely to all attempts by hospitals to refund Medicare overpayments, and (2) include in their hospital audits a review of all Medicare credit balance accounts written off by the hospitals so that Medicare overpayments included in these accounts can be refunded to the program.

BACKGROUND AND REVIEW METHODOLOGY

A credit balance in a Medicare account receivable occurs when a hospital records a higher reimbursement than the amount charged for a specific Medicare beneficiary. A credit balance may be due to an accounting error or to an overpayment by an intermediary. Hospitals must review each Medicare credit balance account to identify an overpayment for refund to the intermediary.

Our national review of Medicare credit balance accounts is being conducted at 76 hospitals and at 9 intermediaries. The objectives of our review are: (1) to determine if hospitals are reviewing Medicare credit balance accounts to identify Medicare overpayments, (2) to determine if hospitals are refunding Medicare overpayments to their intermediary, and (3) to evaluate the intermediaries' oversight controls over hospitals' handling of Medicare credit balance accounts.

Initially our audit approach at each of the selected hospitals was to review all Medicare credit balance accounts recorded on its accounting records as of a specific date. While at one hospital, however, we learned that it had deleted from its

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accounting records Medicare credit balance accounts totaling about $4.9 million. Since it was likely that some of these accounts included Medicare overpayments, we expanded our review at this hospital and others to include accounts written off.

PRELIMINARY RESULTS OF REVIEW

OIG estimates that an additional $200 million in Medicare overpayments remain to be collected by intermediaries.

The preliminary results of our review show that the conditions first reported at eight hospitals and one intermediary are national in scope. Seventy-three of the 76 hospitals included in our review had not refunded Medicare overpayments to their intermediary. Projecting these results nationally, we estimate that hospitals owed the Medicare program $265.9 million. This is about $200 million more than the amount collected so far by intermediaries.

Causes For Medicare Overpayments

There were several causes for these overpayments being made to hospitals. As shown below, most of the causes could be traced to actions taken by the hospitals.

- The $123 million in overpayments, or 46.3 percent, were caused by hospitals billing Medicare and a private insurer for the same service, being reimbursed by both, and keeping both payments. The provisions for the Medicare Secondary Payer program state that Medicare will not reimburse for services if the services are covered by another insurer.

- The $96.6 million in overpayments, or 36.3 percent, were caused by hospitals submitting duplicate billings for services. Most of the claims went undetected by intermediaries because hospitals used different procedure codes, or dates of service for the same service.

- The $19.4 million of overpayments, or 7.3 percent, were caused by hospitals billing for services not performed. Usually this occurred when hospitals mistakenly anticipated that a service would be performed, but was not because of some unforseen circumstance. When the hospitals became aware that the service was not performed, they canceled the charges, thus creating a Medicare credit balance.

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- The $12.7 million of overpayments, or 4.8 percent, were caused by miscellaneous errors made, for the most part, by intermediaries. For example, we found errors in calculating the deductibles and coinsurance amounts, and payments made for non-covered services.

- The $4.8 million of overpayments, or 1.8 percent, were caused by the hospitals billing for an outpatient service that was included in a beneficiary's inpatient claim. Medicare regulations require that any outpatient service performed within a certain number of hours prior to an admission is to be included on the inpatient bill.

- The $9.4 million of overpayments, or 3.5 percent, based on our review of all Medicare credit balance accounts that lacked sufficient information for us to determine the cause of the credit balances. Since some of these credit balances were likely caused by Medicare overpayments, we projected our findings using the results of our review of credit balances for which sufficient information was available.

Causes of Overpayments Not Being Recovered

As indicated in our prior MAR, the primary reason these overpayments were not refunded to the intermediaries was that hospitals were not reviewing their credit balance accounts to determine if Medicare overpayments occurred. However, subsequent to the issuance of that MAR, we determined that intermediaries were not always recovering overpayments even when hospitals attempted to refund them. Fifty-two of the hospitals included in our review unsuccessfully attempted to refund some Medicare overpayments to eight of the nine intermediaries. The hospitals identified the overpayments through review of their Medicare credit balance accounts.

We are concerned that the intermediaries' failure to respond to the hospitals' efforts to refund Medicare overpayments can be misinterpreted by the hospitals as a disincentive to identifying additional Medicare overpayments for subsequent return to the intermediaries. We are currently reviewing the intermediaries' policies and procedures to determine why they did not recover the Medicare overpayments reported by the hospitals. Preliminary indications are that intermediaries are not placing a sufficiently high priority on recovering overpayments, believing that their primary function is to make payments.

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Some Hospitals Wrote Off Medicare Overpayments

Our preliminary results also show that at least five hospitals wrote off Medicare credit balance accounts from their accounting records and kept the overpayments. This condition was first detected at a large nationally known hospital (Hospital).

OIG has identified five hospitals that wrote off Medicare credit balance accounts and kept the overpayments.

Officials there informed us that, as a matter of policy, the Hospital reviewed all Medicare credit balance accounts. For every identified Medicare overpayment, a notice of retraction was sent to the intermediary to initiate recovery action. If the intermediary did not act on the retraction notice within 90 days, the credit balance account was written off the accounting records, refunding efforts were discontinued, and the retraction notices were usually destroyed.

This policy is unacceptable. It allows this Hospital to destroy documentation (retraction notices) showing that at least a minimal effort was made to refund the identified overpayment to the intermediary. Destroying the retraction notices effectively damages the audit trail and hampers efforts of intermediary auditors and others to determine if the Hospital actually attempted to refund identified Medicare overpayments.

More importantly, however, this policy allows the Hospital to keep Medicare overpayments after they had been identified as such. During the period July 1, 1986 through June 30, 1991, the Hospital had written off 901 outpatient accounts and 293 Medicare inpatient credit balance accounts over $1,000. These accounts totaled about $4.9 million. To determine the amount of Medicare overpayments included in these accounts, we randomly selected 100 outpatient accounts from $100 to $10,000 and 107 inpatient accounts from $1,000 to $30,000. In addition, we reviewed all 6 outpatient accounts over $10,000 and all 27 inpatient accounts over $30,000.

Of the 240 Medicare credit balance accounts reviewed, 143 contained Medicare overpayments. The intermediary (Blue Cross and Blue Shield of Maryland) subsequently recovered the overpayments associated with only 6 of the 143 accounts. The Hospital was able to provide us with retraction notices for 20 of the 137 overpayments that were not recovered. It appears that the intermediary did not respond to the Hospital's attempt to refund the 20 overpayments.

Regarding the other 117 overpayments that were written off, the Hospital claimed that it had either reviewed the accounts

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and did not identify an overpayment, or, according to its policy, had sent retraction notices to the intermediary and destroyed them when the accounts were written off. While this may be so (the intermediary had no record of receiving the retraction notices), we noted that of the 20 Medicare overpayments still listed on the Hospital's accounting records, the Hospital was able to provide only 9 retraction notices. This is an indication that the Hospital had not attempted to refund all Medicare overpayments to the intermediary.

We projected[1] the results of our review of Medicare credit balance accounts written off by the Hospital for both inpatient and outpatient accounts. The point estimate for inpatient overpayments written off was $1,145,302 with a standard error of $79,221. The point estimate for outpatient overpayments was $293,559 with a standard error of $74,320.

We have identified four other hospitals that also wrote off Medicare credit balance accounts. The amounts written off were not nearly as significant as the amount written off by the Hospital. However, one of these hospitals--located in New Jersey--wrote off $261,593 in Medicare overpayments and kept the funds.

Conclusions and Recommendations

Our national audit is nearing completion. Draft or final audit reports have been issued to the hospitals included in this review. We are in the process of issuing consolidated reports to the intermediaries. Rather than awaiting the finalization of our reports to the hospitals, we chose to alert HCFA of pressing problems that require immediate attention. Our initial report, issued on August 29, 1991, was acknowledged by HCFA's timely and aggressive response which adequately addressed all of the recommendations contained therein.

However, new developments resulting from our ongoing review show that additional HCFA action is necessary. Our preliminary projection of the Medicare overpayments owed by the hospitals versus the amounts currently recovered by the intermediaries is a clear indication that HCFA should continue its aggressive pursuit of recoveries. Further, subsequent to our initial report, we identified a disturbing pattern among the intermediaries reviewed. The intermediaries did not aggressively pursue recovery of some Medicare overpayments

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[1] This projection was not included in our national projection of overpayments because credit balance accounts written off were not originally included in the scope of our audit.

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reported by 52 hospitals. Less frequently found, but no less disturbing, was the practice of some hospitals to write off Medicare credit balance accounts from their accounting records and keep all Medicare overpayments within these accounts.

These findings were not included in our prior report nor reflected in our previous recommendations. We believe that these findings must be addressed if HCFA is to ensure that Medicare overpayments made to hospitals are refunded to the program.

We, therefore, recommend that HCFA:

1. Continue its plan of recovery by requiring hospitals to report Medicare credit balance accounts to intermediaries on a quarterly basis.

2. Supplement its previous instructions to intermediaries by requiring them to:

    a. Respond in a timely manner to all hospitals' attempts to refund Medicare overpayments that they identified through review of Medicare credit balance accounts.

    b. Include in their hospital audits a review of Medicare credit balance accounts that were written off by the hospitals. All identified Medicare overpayments should be refunded to the program.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HOSPITAL CLOSURE: 1990

INTRODUCTION

PURPOSE

To describe the extent, nature, reasons for, and impact of hospital closure in 1990.

This report is a follow-up to the recent Office of Inspector General (OIG) studies entitled "Hospital Closure: 1987" (OAI-04-89-00740), issued in May 1989, "Hospital Closure: 1988" (OEI-04-89-01810), issued in April 1990 and "Hospital Closure: 1989" (OEI-04-90-02440), issued in January 1991.

This study was requested by the Secretary of the Department of Health and Human Services.

BACKGROUND

In the past several years, the closure of general, acute care hospitals has generated increasing public and congressional concern. According to a number of recent studies, more hospitals are expected to close in coming years. Numerous questions have been raised about the reasons for and the impact of hospital closure, as well as implications for public policy.

At the request of the Secretary of the Department of Health and Human Services (HHS), the OIG released an inspection in May 1989 describing the extent, nature and impact of hospital closure in 1987 in the United States. That study showed that 69 hospitals closed in 1987. The results were presented to the Secretary, the Assistant Secretaries of HHS, and staff of the Health Care Financing Administration (HCFA) and the Public Health Service (PHS). The Inspector General testified before the U.S. House Ways and Means Subcommittee on Health regarding the study findings. Many of those informed of the study of 1987 hospital closures encouraged the Inspector General to continue analysis of the phenomenon to detect differences in the rate of hospital closure and in the characteristics and circumstances of hospitals that close.

Similar inspections of 1988 hospital closures and 1989 hospital closures showed that 88 and 76 hospitals closed respectively.

The findings from the 1987, 1988 and 1989 studies were similar. The hospitals that closed were small and had low occupancy rates. When the hospitals closed, few patients were affected. Most could get medical care nearby.

SCOPE

We examined hospitals that closed in calendar year 1990.

For purposes of this study, the following definitions were used.

Hospital: A facility that provides general, short-term, acute medical and surgical inpatient services.

Closed Hospital: One that stopped providing general, short-term, acute inpatient services in 1990. If a hospital merged with or was sold to another hospital and the physical plant closed for inpatient acute care, it was considered a closure. If a hospital both closed and reopened in 1990, it was not considered a closure. If a hospital closed in 1989, reopened in 1990, and closed again in 1990, it was counted as a closure for 1989 but not again in 1990.

METHODS

To determine the extent and nature of hospital closure, we obtained information from HCFA data bases. To determine reasons for and impact of hospital closure, we interviewed State hospital associations, State licensing and certification agencies, State health planning agencies, officials associated with closed and nearby hospitals, and local public officials.

Appendix A describes information collection methods in further detail.

FINDINGS

The Inspector General's study of hospitals closed in 1990 showed that:

- Fifty-six general, acute care hospitals closed in 1990. Twenty fewer hospitals closed in 1990 than in the previous year.
- Most hospitals that closed were small and had low occupancy rates.
- When a hospital closed, few patients were affected.
- Although residents of a few communities had to travel greater distances, most had emergency and inpatient medical care available within 20 miles of the closed hospital.

EXTENT AND NATURE OF HOSPITAL CLOSURE

How Many Closed?

In 1990, there were more than 6,800 hospitals in the United States. Of those, 5,466 were general, short-term, acute care hospitals entered on HCFA's data base as participating in the Medicare program. Fifty-six (56) hospitals closed in 1990 -- 1 percent of all hospitals nationally. Twenty fewer hospitals closed in 1990 than in the previous year.

HOSPITALS IN THE U.S.:	5,466
CLOSED IN 1990:	56 (1.0%)

When they closed, the general, acute care inpatient bed supply was reduced by 3,694 beds, or 0.4 percent.

Where Were They?

The closed hospitals were located in 26 States. The greatest number of closures was in Texas (10), followed by California (7), Massachusetts (4), and Louisiana (4). These 4 States represented 45 percent of the closures. Thirteen States had one closure each. Appendix B lists the 1990 closures by State.

One percent of all rural hospitals nationally closed in 1990. Similarly, 1 percent all urban hospitals nationally closed in 1990.

	RURAL	URBAN
HOSPITALS IN THE U.S.:	2,667	2,799
CLOSED IN 1990:	28 (1.0%)	28 (1.0%)

How Many Opened?

While 56 hospitals closed in 1990, 7 new, general, acute care hospitals opened, adding 700 beds to the national supply of beds.

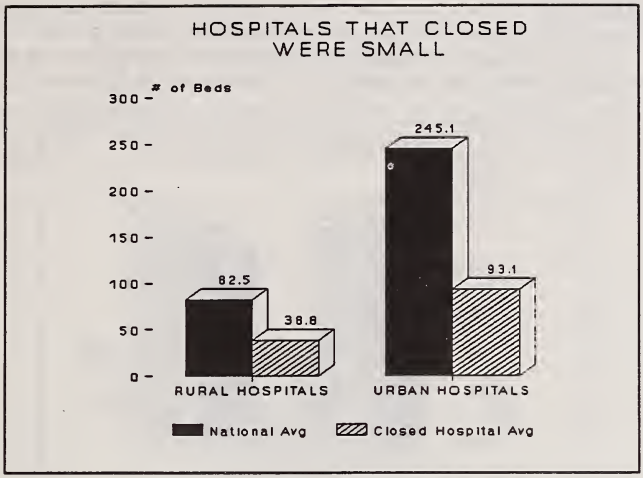
In addition to the new openings during 1990, 2 hospitals that closed prior to 1990 reopened in 1990, adding another 61 beds.

What Were the Closed Hospitals Like?

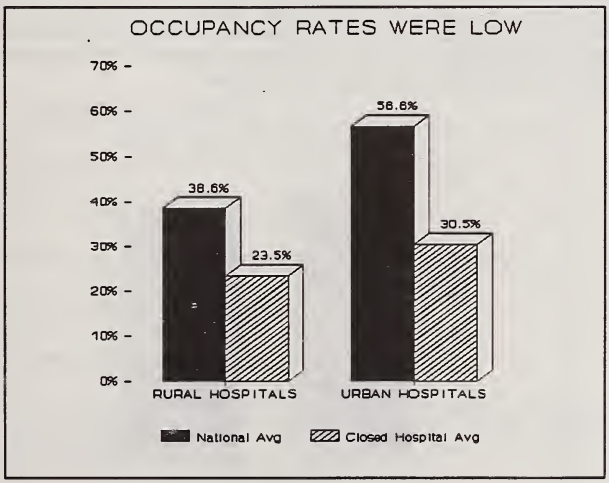
Size: Hospitals that closed in 1990 were small. More than three-quarters had fewer than 100 beds.

SIZE OF CLOSED HOSPITALS				
Number of Beds	Rural	Urban	Total	Percent
0 - 29	12	4	16	28.6
30 - 49	10	4	14	25.0
50 - 99	5	2	14	23.2
100 - 199	4	10	11	19.6
200 - 299	0	2	2	3.6
300 >	0	2	0	0.0
TOTALS	28	28	56	100.0

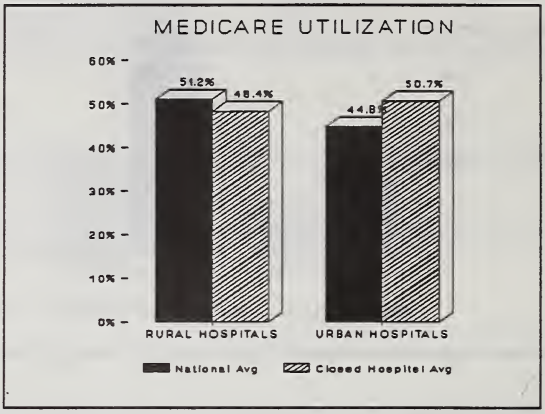
Closed hospitals in both rural and urban areas were much smaller than the national averages. Rural hospitals that closed were less than half the size of the average rural hospital nationwide (38.8 beds vs. 82.5 beds). Urban hospitals that closed were even smaller than the average urban hospital nationwide (93.1 beds vs. 245.1 beds).



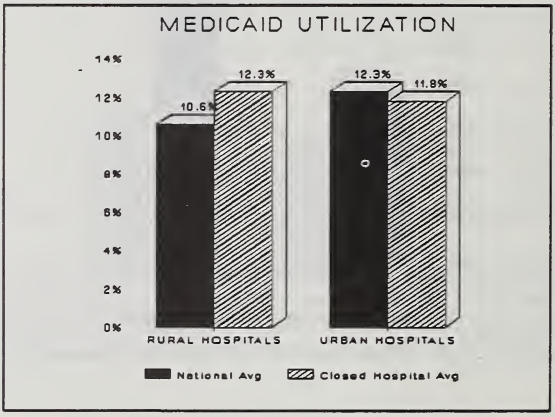
Occupancy: Occupancy rates for closed rural and urban hospitals were much lower than the national average.[1]



Medicare Utilization: In rural areas, the average Medicare utilization among hospitals that closed was slightly lower than the rural national average (48.4 percent vs. 51.2 percent). In urban areas, the average Medicare utilization among hospitals that closed was higher than the urban national average (50.7 percent vs. 44.8 percent).[2]

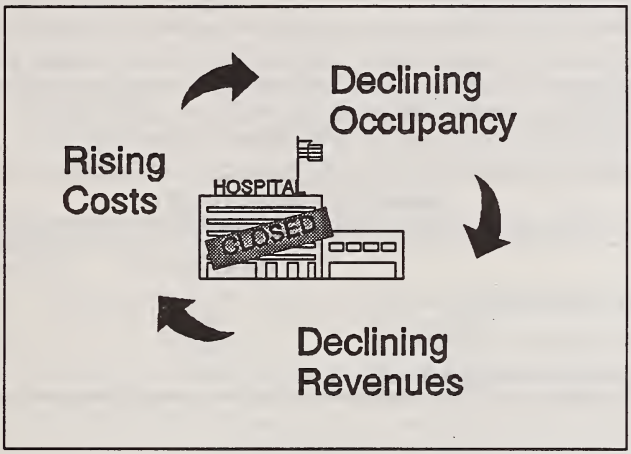


Medicaid Utilization: In rural areas, the average Medicaid utilization among hospitals that closed was slightly higher than the rural national average (12.3 percent vs. 10.6 percent). Minimal differences existed in the average Medicaid utilization among urban hospitals that closed and all urban hospitals nationally.[3]



Why Did They Close?

As in our previous hospital closure studies, the many health care professionals interviewed for 1990 closures reported no single reason for hospital closure. Hospitals close because of the interrelated factors of declining occupancy, lagging revenues and rising costs. Hospital viability was said to depend on the stability of all three factors. The weakening of one may begin a chain reaction eventually leading to hospital closure.



IMPACT OF HOSPITAL CLOSURE

In communities where hospitals closed in 1990, we assessed the:

- number of patients affected by closure of hospitals;
- availability of inpatient care and emergency medical services; and
- current use of the closed hospital facility.

How Many Patients Were Affected?

Few patients were affected by hospital closure. For rural hospitals that closed in 1990, the average daily census in the year prior to closure was nine patients. The urban hospitals had an average daily census of 28 patients.

WHEN HOSPITALS CLOSED, HOW MANY PATIENTS WERE AFFECTED?		
	Rural Hospitals	Urban Hospitals
Average Number of Beds	38.8	93.1
Average Occupancy Rate	x 23.5%	x 30.5%
Average Patient Census	9.1	28.4

We analyzed Medicare utilization data to determine the number of elderly patients affected by hospital closure in 1990. In rural hospitals that closed, four Medicare patients were in the hospital on an average day in the year prior to closure. In the urban hospitals that closed, there were 14 Medicare patients on an average day.

WHEN HOSPITALS CLOSED, HOW MANY MEDICARE PATIENTS WERE AFFECTED?		
	Rural Hospitals	Urban Hospitals
Average Patient Census	9.1	28.4
Average Medicare Utilization Rate	x 48.4%	x 50.7%
Average Number Medicare Patients	4.4	14.4

Are Inpatient Care and Emergency Services Available?

We assessed availability of inpatient and emergency medical care in miles from closed hospitals to the nearest inpatient and emergency facilities.

Inpatient Care: In most communities where a hospital closed in 1990, inpatient hospital care was available nearby.

Rural: Residents in 18 of the 28 rural communities where a hospital closed could get inpatient care within 20 miles of the closed hospital.

Residents of 3 rural communities had to travel more than 30 miles for inpatient care.

Urban: In all but 2 of the 28 urban communities where a hospital closed in 1990, inpatient care was available within 10 miles of the closed hospital.

NEAREST INPATIENT CARE TO CLOSED HOSPITALS		
	NUMBER OF CLOSED HOSPITALS	
DISTANCE	Rural	Urban
Within 10 miles	9 (32%)	26 (93%)
11-20 Miles	9 (32%)	2 (7%)
21-30 Miles	7 (25%)	0 (0%)
More than 30 Miles	3 (11%)	0 (0%)
Totals	28 (100%)	28 (100%)

Emergency Services: When a hospital closed, the community lost not only inpatient beds, but also emergency services.

Rural: In all 28 communities where rural hospitals closed, emergency care facilities were available within 30 miles of closed hospitals.

In all but 4 of the 28 rural communities where hospitals closed, emergency care facilities were available within 20 miles of the closed hospital. In those four communities, ambulance services and physician services were available.

NEAREST EMERGENCY SERVICES TO CLOSED RURAL HOSPITALS	
DISTANCE	NUMBER OF CLOSED HOSPITALS
Same Town	8
Within 10 miles	6
11-20 miles	10
21-30 miles	4
More than 30 miles	0
Total	28

Urban: In all but 4 urban communities where a hospital closed, emergency care facilities were less than 5 miles from the closed hospital. In 3 of those 4 communities, emergency care facilities were within 10 miles from the closed hospital. Residents of the fourth community, Buna, Texas, must travel 15 miles for emergency care. That community has physician services and ambulance services available.

What Is the Building Used For Now?

At the time of our review, 31 of the 56 closed hospital buildings (55 percent) were being used, primarily for health-related services. For example:

- McCone County Hospital in Circle, Montana was converted to a Medical Assistance Facility. It provides 24-hour emergency services, outpatient care and up to 4 days of inpatient care.
- Holden Hospital in Holden, Massachusetts was converted to an urgent care center.
- Sardis Community Hospital in Sardis, Mississippi and Iola Hospital in Iola, Wisconsin became nursing homes.
- Westland Medical Center in Westland, Michigan offers substance abuse and psychiatric services in the former hospital building.

The following chart illustrates the use of all 56 hospital facilities after closure in 1990.

USE OF CLOSED HOSPITALS		
Use of Building	Number of Former Hospitals*	
	Rural	Urban
Specialty Treatment Facility (e.g. chemical dependency)	4	3
Long Term Care Facility	4	4
Outpatient Services/Clinic	8	7
Offices	2	2
Social Services	4	0
Vacant	10	15

*Duplicate count. In 7 of the 56 former hospitals more than 1 service is now offered.

Plans were being made for using 8 of the remaining 25 vacant hospitals for health-related services. For example, Modesto City Hospital in Modesto, California will be converted to a Rehabilitation hospital. Plans were being made for two of the closed facilities to reopen as acute care hospitals.

SUMMARY

Fifty-six hospitals closed in 1990 - 20 fewer than in 1989. Their characteristics were very similar to hospitals that closed in 1987, 1988 and 1989. Most hospitals that closed in 1990 were small and had low occupancy. When a hospital closed, few patients were affected. Although residents of a few communities had to travel greater distances for hospital care, most had emergency and inpatient medical care available within 20 miles of the closed hospital.

ENDNOTES

1. Hospital occupancy rate is defined as the actual number of patient days divided by the total bed days available. National occupancy rate is defined as the sum of all hospitals' occupancy rates, divided by the number of hospitals.

2. Average Medicare utilization of closed urban and rural hospitals is defined as the percent of Medicare patient days compared to the total patient days for each hospital, summed and divided by the number of hospitals. National average Medicare utilization is the percent of Medicare utilization of each hospital, summed and divided by the total number of hospitals.

3. Medicaid utilization is calculated in the same way as Medicare utilization.

APPENDIX A

METHODOLOGY

Extent and Nature of Hospital Closure

To determine how many hospitals closed in 1990, we contacted all 50 State licensing and certification agencies. We also contacted State hospital associations and State health planning agencies. When a closed hospital met the study's definition or when there were questions, we contacted officials associated with the closed hospitals and officials associated with hospitals nearest to the closed hospital.

To determine the number of hospitals in the United States, we used the Hospital Cost Report Information System (HCRIS) maintained by the Health Care Financing Administration (HCFA). We included only the general, short-term, acute care hospitals under Medicare's Prospective Payment System (PPS) in the universe. There were 5,466 hospitals listed on HCRIS as short-term, acute care, general hospitals for the sixth year of PPS (PPS 6).

To analyze characteristics of closed hospitals, we used HCFA's HCRIS data. We used the latest pre-closure cost reports. For example, if a hospital closed in May 1990 and its accounting year was on a January-December cycle, we used the provider's January 1, 1989 to December 31, 1989 report.

We contacted officials of the following organizations to determine the reasons for 1990 hospital closure:

- State hospital associations
- State health planning agencies
- State certification and licensing agencies
- Closed hospitals
- Nearest hospitals to closed hospitals

Impact of Hospital Closure

We limited our "impact" analysis to distance from a closed hospital to the nearest still-operating hospitals and to emergency services. We obtained data for our analysis from the following sources:

- Former hospital administrators, board members, and/or staff of closed hospitals
- Hospital administrators and/or staff at the nearest hospitals
- Local police and health officials
- Local government officials
- State health planning agencies
- State certification and licensing agencies
- State hospital associations

APPENDIX B

State	Total Closures	Rural Closures	Urban Closures
Texas	10	7	3
California	7	2	5
Louisiana	4	4	0
Massachusetts	4	0	4
Arkansas	2	2	0
Colorado	2	2	0
Florida	2	0	2
Georgia	2	0	2
Illinois	2	1	1
Michigan	2	0	2
New York	2	0	2
Oklahoma	2	0	2
Washington	2	0	2
Alabama	1	1	0
Iowa	1	1	0
Arizona	1	0	1
Mississippi	1	1	0
Montana	1	1	0
New Hampshire	1	1	0
New Mexico	1	1	0
Nevada	1	0	1
Ohio	1	0	1
Oregon	1	1	0
Vermont	1	1	0
Wisconsin	1	1	0
West Virginia	1	1	0
26 States	56 Closures	28 Rural	28 Urban

APPENDIX C

1990 HOSPITAL CLOSURES BY NAME AND LOCATION			
Hospital Name	City	State	Rural/ Urban
Cleburne Community Hospital and Nursing Home	Heflin	AL	rural
Buffalo Island Hospital	Manila	AR	rural
Dermott-Chicot Memorial Hospital	Dermott	AR	rural
Valley View Community Hospital	Youngstown	AZ	urban
Rancho Encino Hospital	Encino	CA	urban
Community Hospital of Salinas	Salinas	CA	urban
Mendocino Community Hospital	Ukiah	CA	rural
Modesto City Hospital	Modesto	CA	rural
Fowler Community Hospital	Fowler	CA	urban
AMI Community Hospital of Santa Cruz	Santa Cruz	CA	urban
Marina Hills Hospital	Los Angeles	CA	urban
Washington County Public Hospital	Akron	CO	rural
La Plata Community Hospital	Durango	CO	rural
Centro Asturiano Hospital	Tampa	FL	urban
North Miami Medical Center	Miami	FL	urban
Physicians and Surgeons Hospital	Atlanta	GA	urban
Atlanta Hospital	Atlanta	GA	urban
Community Memorial Hospital	Postville	IA	rural
Central Community Hospital	Clifton	IL	urban
Douglas County Jarman Memorial Hospital	Tuscola	IL	rural
Rayne-Branch Hospital	Rayne	LA	rural
E.S. Pike Memorial Hospital	Kentwood	LA	rural
St. Luke General Hospital	Arnaudville	LA	rural
Plaquemines Parish General Hospital	Port Sulpher	LA	rural
Holden Hospital	Holden	MA	urban
Hunt Hospital	Danvers	MA	urban
Massachusetts Osteopathic Hospital and Medical Center	Boston	MA	urban
St. Lukes Hospital of Middleborough	Middleboro	MA	urban
Westland Medical Center	Westland	MI	urban
Northwest General Hospital	Detroit	MI	urban

1990 HOSPITAL CLOSURES BY NAME AND LOCATION (cont.)			
Hospital Name	City	State	Rural/ Urban
Sardis Community Hospital and Nursing Home	Sardis	MS	rural
McCone County Hospital	Circle	MT	rural
Newport Hospital	Newport	NH	rural
Valencia Presbyterian Hospital	Belen	NM	rural
Incline Village Community Hospital	Incline Village	NV	urban
Tioga Community Hospital	Waverly	NY	urban
Adirondack Regional Hospital	Corinth	NY	urban
St. John Hospital	Cleveland	OH	urban
Hominy City Hospital	Hominy	OK	urban
Doctors General Hospital	Oklahoma City	OK	urban
St. Helens Hospital and Health Center	St. Helens	OR	rural
Hico Community Hospital	Hico	TX	rural
Corpus Christi Osteopathic Hospital	Corpus Christi	TX	urban
Charles R. Drew Medical Center	Houston	TX	urban
E.L. Graham Memorial Hospital	Cisco	TX	rural
Ranger General Hospital	Ranger	TX	rural
[illegible]leson Memorial Hospital	Caldwell	TX	rural
Harris Methodist - Dublin	Dublin	TX	rural
David Granberry Memorial Hospital	Naples	TX	rural
Buna Medical Center Hospital	Buna	TX	urban
Hubbard Hospital	Hubbard	TX	rural
Rockingham Memorial Hospital	Bellows Falls	VT	rural
West Seattle Community Hospital	Seattle	WA	urban
Saint Cabrini Hospital of Seattle	Seattle	WA	urban
Iola Hospital	Iola	WI	rural
Wyoming General Hospital	Mullens	WV	rural

Mr. DINGELL. Mr. Kusserow, the committee thanks you for your very helpful report.

The Chair recognizes first the gentleman from Virginia, Mr. Bliley.

Mr. BLILEY. Mr. Kusserow, your report discusses a curious permutation of the term of writing off in regard to credit balances. It would appear that hospitals let these balances sit on the books for a certain amount of time after which they write off the credit and transfer it to their cash account. Is this indeed what happens?

Mr. KUSSEROW. We are finding many examples where that is occurring. I will tell you, we have come across situations where hospitals are aging their payables. It is understandable. If you are the one that is owed the money, you might age out the money. But I have got to tell you, I have never heard of a situation where you age it out and get the benefit of that money. There is movement of that money after a period of time, very commonly across the country to their own benefit.

Mr. BLILEY. When you say "very commonly," what kind of percentage of hospitals?

Mr. KUSSEROW. It is difficult, because there is a little gap point in there. I am not really sure what happened. We do know after the 1986 report, recoveries against credit balances brought that number way down. We do know we have looked now back over the last 3 years and it is building back up.

In between, I am not sure I know what happened. Did they write that stuff off? What happened to that money? So I can't speak to the full length.

For us to really find out what has happened in the past as to money that is maybe now lost, it will take a full and complete audit of the entire books over a long period of time at those hospitals to see how that money moved. That is a very, very difficult process.

Mr. BLILEY. Thank you. I was under the impression that "writing off" referred to debts, not credits. If an entity for whatever reason, after a specified period of time, deemed an amount uncollectable as a bad debt, I am familiar with that; you adjust your books accordingly. But I am not familiar with writing off credits. Is this a common accounting tool?

Mr. KUSSEROW. It may be common, but it is not an acceptable thing. It is very strange, in fact, that you would have a situation where you owe somebody else the money and your kind of procedure would say that if you owe it to him long enough, you don't have to pay it any more. That is what the creditor might say. You might be a bad debt, but when you owe the money, to say you no longer owe that money, that is totally unacceptable. It may be unacceptable in accounting practice. Going back, we are seeing that is precisely what is happening. That is not correct and that is not appropriate and should not be allowable.

Mr. DINGELL. Would the gentleman yield?

Mr. BLILEY. Yes.

Mr. DINGELL. Maybe a bad debt to the Government should be written off?

Mr. KUSSEROW. They say if Uncle hasn't got it from us yet, that will clear us out of the bad debt and use the money for some other purpose.

Mr. DINGELL. I thank the gentleman for yielding.

Mr. BLILEY. Your report states that at least one hospital, after writing off its overpayment credits, destroyed its so-called retraction notices documentation showing that at least a minimal effort was made to refund the identified overpayment to the intermediary. Is that a proper action to destroy the document?

Mr. KUSSEROW. No. In fact, any time there is a fortuitous loss or disappearance of records, we don't look upon it very kindly, and we think it is an improper practice.

Mr. BLILEY. What harm is done?

Mr. KUSSEROW. By destroying the records, what you have done is in fact canceled the debt you owed to Uncle Sam. It really isn't to Uncle Sam; it really belongs to the trust funds. That money is paid back to Medicare. When you destroy the records, you cancel your debt.

I will say this: If that is done willfully, with the intent to accomplish just that, as far as I am concerned, that constitutes a criminal violation of law.

Mr. BLILEY. To what extent did you find Medicare and Medicaid payments to be a significant factor in hospital closures?

Mr. KUSSEROW. As I pointed out—I will reframe it a little bit. If you have got a 40-bed hospital that has only a 25-percent occupancy rate, that means only 10 of the 40 are occupied. That means 30 beds are not occupied. If you have 50 percent of the beds occupied by Medicare beneficiaries, that is 5 beds out of 40. No matter how much Medicare will pay for the 5, it cannot cover the overhead cost of the 40-bed hospital.

For that reason, we have found consistently, across the board, the problem is not Medicare paying enough, it is the fact you do not have enough patients in the hospital to be viable.

Why aren't they in the hospital? In every single hospital closing, we find it is the physicians that say that they will send their patients to the facility that is best equipped to handle the problem that the patient is confronted with. Why don't you do the local hospital? If the person is going in for a bypass, you are not going to have it at the local hospital where they have never had bypass surgery.

It really comes down to the fact that physicians are not putting patients in these hospitals enough to keep them viable to cover the overhead cost.

Mr. BLILEY. Thank you, Mr. Kusserow. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair recognizes now the gentleman from Ohio, Mr. Eckart.

Mr. ECKART. To follow up on Mr. Bliley's questions, the issue isn't one of reimbursement, it is one of utilization and occupancy?

Mr. KUSSEROW. That's correct.

Mr. ECKART. Because the statistics in the closed hospitals, half of their patients may have been Medicare and Medicaid reimbursed?

Mr. KUSSEROW. It goes back to the hypothetical situation. Only five beds are occupied. Five beds, no matter what you pay for those

five beds, aren't sufficient to keep that hospital viable. You have to have more patients in there.

Mr. ECKART. Can you tell us a little bit about how those closed facilities are being used now?

Mr. KUSSEROW. We have been very interested in this. We have another study we are going to initiate—because we have been kind of excited about what we have encountered—tangential to the issue of why hospitals are closing. That is that many communities have decided they do not want to lose the benefit of that facility. They are doing a lot of innovative things out there.

One of the things we have noticed is that the hospitals spring back as health care facilities. They might go from acute care hospital into a site facility or alcohol rehabilitation facility, or other kinds of medical services other than acute inpatient kind of services.

Mr. ECKART. Does that affect emergency services as well?

Mr. KUSSEROW. Yes. There is an awful lot of innovation going on there where many kinds of emergency services are provided with limited stays, but some of the more complicated procedures you would expect from an acute care facility are not being serviced there.

So if you broke a leg, you could have a patient go to that facility. But if a person has a stroke or has cardiac arrest, they might bypass that facility and take them to a larger facility with a full range of services for that patient.

There is an awful lot that is going on of a highly innovative nature. The institution of the hospital itself has disappeared. They have not taken a bulldozer and done away with it. It gets changed, or in some cases what you see is it comes back as a hospital with a new support as part of a chain or merged operation.

Mr. ECKART. On the issue of emergency services, once the hospital closed, are they available in the area?

Mr. KUSSEROW. We have found it is available. Access to services are not lost. In fact, in an overwhelming majority of the situations, there is another hospital within 20 miles, and with an ambulance, they get there quickly.

Mr. ECKART. Is that true in rural areas?

Mr. KUSSEROW. I was fumbling through here. I had an example of one hospital that had closed.

To give you an example, there was only one rural hospital of the 158 we examined over the last 4 years where emergency care was more than 30 minutes away. That was in Mullen, NE.

In that case, the patient had an hour's ambulance ride to the emergency room. It was an unusual situation. It was a nine-bed hospital. It had 4-percent occupancy rate, which meant only one bed in that hospital was occupied every third day. So that is the only exception to the general rule that I have given you about the access.

As part of this other study we are doing, we are very much interested in rural America, and we are finding that a lot of services are being provided by helicopter. They are developing networks whereby they can lift patients to acute care facilities when needed, because I certainly don't have to tell you, in your neck of the woods in mid-winter, 20 miles can be a long distance. It can be a long dis-

tance if you are up in Idaho and 20 miles is across the mountain pass in mid-winter. You can't just put down distance. You have to put down time to the hospital, and we are watching rural America being serviced by helicopter services as well as surface vehicles.

Mr. ECKART. Helicopter services may be more expensive. What is the impact of more closures?

Mr. KUSSEROW. The overall impact is negligible, or what impact it is having on occupancy rates nationwide. If you want, you could make the case these hospitals which are inefficient that are closing, they are removing a health hazard to people who are in serious conditions.

Also, you are taking facilities that are not physically viable. Those patients are shifting over to other facilities.

What we have tried to track is cumulative over the last 4 years to see if there is a pattern of closings that's impacting on certain parts of the country more than others.

Mr. ECKART. That was my next question.

Mr. KUSSEROW. Although they are distributed pretty widely across the country, there are certain States just by the geography that had a lot of real tiny hospitals, but they were disbursed across the geography.

Also, with the demographic trends of the last couple of decades, whatever population there had been there to support the hospital has left. You have that problem.

We also note that many of the hospitals that are closing were hospitals that were built back in the 1940's under the Hill-Burton Program, whereby one of the objectives was to try to attract physicians to communities by building hospitals in communities that did not have physicians.

That end was not achieved, by and large. In fact, building a 10-bed hospital did not guarantee a physician would want to practice there. So you had many of these hospitals that were very weak to begin with, because they did not have physicians. Physicians did not come in. With the population shifting, it just doesn't make any sense to maintain the hospital.

Mr. ECKART. Thank you very much, Mr. chairman. I yield back to the chairman.

Mr. DINGELL. The time of the gentleman has expired.

The Chair recognizes the gentleman from Georgia, Mr. Rowland.

Mr. ROWLAND. Does the lack of utilization that you referred to in rural hospitals relate in any way to Medicare credit balance accounts? Is there any relationship that exists between those two?

Mr. KUSSEROW. We have not been able to establish that, because as we look at the hospital closures and samples of the hospitals we are looking at with excess credit balance, we are not getting enough interplay between them to see whether they had excess credit balance at the time they close.

The other part of the problem we have on that, Dr. Rowland, is by looking at the universe of the 1,500 largest hospitals that have 200 beds or more. The hospitals that are closing, both urban and rural, tend to be much smaller hospitals

So there is an information gap there. We could try to work the data and see if we could come up with tentative findings, but what

we do come up with, I would caution, would be lacking in some reliability.

Mr. ROWLAND. Does the fact that everybody gets a credit balance account exists necessarily mean there is a Medicare overpayment?

Mr. KUSSEROW. Not necessarily. As you look in the credit balance, you try to find out what is there. You may find out in the reconciliation process there may be accounting errors or there may be other reasons why it is there, and it can legitimately move out of that category.

So looking at the excess credit balance account and saying it is 100 percent of what it is, no. The information we have provided is after we have reconciled, we looked at what is Medicare excess credit balances. That is what we are reporting on.

We had to go to this reconciliation process, so 50 percent was not ours. In the excess credit balances, you also have commercial health insurers that also had excess credit balances, so we could not count that. We only looked at Medicare.

Mr. DINGELL. Would the gentleman yield?

Mr. ROWLAND. Yes.

Mr. DINGELL. I believe I heard you say these credit balances do not accrue interest on behalf of the Federal Government?

Mr. KUSSEROW. The rules followed are if I would go audit them and say over the last 3 years, "This is what you owe us," they would start charging interest not from when it comes due.

I would submit to you, though, that if you in the private sector owed money to somebody, believe me, they will charge you from the date on which that debt came about, and you would be paying interest from that date.

I think then one of the things I have always favored; the date you start accruing interest, is the day the debt got started.

Mr. DINGELL. Thank you.

Mr. ROWLAND. What was the money in these credited accounts invested in? Some sort of interest bearing certificates or whatever?

Mr. KUSSEROW. It would be like anything else in managing a business. You would have accounts where money would be placed. But in terms of having a CD set aside for the one item credit balance, no, they don't have that. It would be a cash flow situation where they have excess revenue over expenditures. It would be parked in some sort of an interest-bearing account.

Mr. ROWLAND. In a general fund?

Mr. KUSSEROW. Yes. The concern I have is I cannot tell you—and it bothers me I cannot—how much shifted out of credit balance accounts and went into the general fund of the hospital and disappeared and would not go back to Medicare.

Mr. ROWLAND. Can you tell me something about the way the hospitals reviewed this and what kind of records they kept on that? Did they really do a good job in reviewing it?

Mr. KUSSEROW. Of course, that varies enormously across the country. As I pointed out in my testimony, we did find hospitals that did go on notice with the intermediaries saying we did have an excess balance. Since it was not reconciled, I don't know how forthcoming, whether it was a part of it. But the hospitals were not trying clearly to hide the fact that they owed money back to Medicare for the excess credit balances.

But again, if you look at credit balances, they are generated when a patient comes in and they may be billed multiple third party payers. They might bill Medicare and their VA or health insurance, or maybe you have an accident insurance policy, and they bill everybody.

I don't have to tell you that when you go into a hospital, they bill everybody that moves, walks, or thinks, if they have a chance to get the money. The money comes in and that is appropriate.

But Medicare is a secondary payer. If they get payment from another source, such as private health insurance or accident insurance from a company, then they are supposed to reconcile that and pay the difference back to Medicare.

Sometimes what we do find, as I pointed out, 36 percent of the money we found in the excess credit balances, where they billed twice for the same service. Those things happen, and there is no problem. But when they discovered it, they should have then paid the difference back to Medicare.

Our problem is they did discover it, and in many cases they did not pay that back.

We also have the situation where other types of errors occur, where a surgery or some sort of procedure has been scheduled, but for some reason it was canceled, so they had billed Medicare for the service that had never come about. That happens in the normal course of hospital business.

The problem does arise that when the money comes in from Medicare, it then should be reconciled. When it is not performed, it should go back.

So there are a lot of little things like that which call for reconciliation.

Mr. ROWLAND. Mr. Chairman, I would like to follow up on a comment you made a moment ago.

You said Medicare is a secondary payer?

Mr. KUSSEROW. Yes, depending on the circumstances. It is not first in line to pay the bill. It stands behind other insurance.

Mr. ROWLAND. I want to clarify this. If an individual is retired, 67 years old, retired, they have Medicare, and they also have some other insurance; which is the primary payer?

Mr. KUSSEROW. Depending on the circumstances, the primary payer could be the insurance. If that person steps out in front of an automobile and gets hit by a car, then you go to an insurance policy. If it is a hit-and-run, then Medicare would pay.

I go to the situation where the 67-year-old beneficiary steps in front of an automobile, that trauma—and oftentimes there may be another payer there, then that insurance company might be billed and might have to be paid for.

Mr. ROWLAND. What is the incentive for an individual——

Mr. KUSSEROW. I don't want to leave this arena and not have it completely covered.

The kind of insurance you also have to deal with is, let's say you have a spouse of the 67-year-old beneficiary who is working, and let's say under the employment plan of that spouse, they have insurance that covers the beneficiary. Again, you are looking for that coverage to play into the thing. You don't put Medicare at the front of the line in that case; it is back end.

Mr. ROWLAND. Why would an individual have their own private insurance and pay that if they were also eligible for Medicare?

Mr. KUSSEROW. In most cases again, we want to differentiate the kind. Where you have secondary payment problems is not where you have the retiree, which comes in behind Medicare, to make up the difference, but where you might have the situation where the spouse is working and has insurance coverage that should cover first.

Mr. ROWLAND. Medicare is the primary payer if there is no primary?

Mr. KUSSEROW. Yes. You can have a beneficiary who might elect to have another insurer to make up the difference.

Mr. ROWLAND. Thank you.

Mr. DINGELL. The Chair thanks the gentleman.

I would like to get a look at this relationship between the Federal Government, intermediaries, and the suppliers. The intermediaries would be something like Blue Cross, or Blue Cross of Washington, DC., or some other insurance company?

Mr. KUSSEROW. Basically it goes back to 1965, when there was great controversy on medical practice in the United States. The compromise was, you would pay all of the charges, you would use the existing health insurance system as the payment agent. Thus you have the Blue Cross and Blue Shields of the world as fiscal intermediaries for part A, and then also under part B.

Mr. DINGELL. There are some 56 of these, is that correct?

Mr. KUSSEROW. Yes.

Mr. DINGELL. Their function is to serve as a surrogate or agent for the Department of Health and Human Services in dispensing these public moneys; is that correct?

Mr. KUSSEROW. Exactly. They do certain services. One you can just sort of imagine as if it is an electronic payment. They may do pre- and post-payment review. You don't have a problem with it.

The third function is an audit function to make sure the game is being played according to the rules. But it all comes back to the same thing. They act as the agents for the Health Care Finance Administration and Medicare Program.

Mr. DINGELL. What kind of contract do these intermediaries have with the Federal Government? Do they have any contractual responsibility to audit?

Mr. KUSSEROW. A substantial amount.

Mr. DINGELL. For Federal moneys.

Mr. KUSSEROW. A substantial amount goes into payment safeguards. We are talking about a ton of money.

Mr. DINGELL. Are they subjected to penalties?

Mr. KUSSEROW. They have an evaluation system where they have a point rating, and weigh it as to what the first priority, second, and third priority, and they will rate as to how they have gone in these areas.

The concerns I had raised in my testimony was that the excess credit balances don't even come up on the screen, and therefore, there is no incentive for them to do a good job, which they consider not material. They have these tens of millions of dollars; it is not significant.

Mr. DINGELL. They say $200 million is also not significant?

Mr. KUSSEROW. That is what it comes down to. They just do not place this as a very high priority area.

One of the disturbing things I mentioned that came out of the 1986 report is they had 2 hard years of budget cutbacks in this arena, so all the promises about how they were going to cure the problem we had raised, that we raised in 1986, sort of got shuttled in the back, and we see that excess credit balance going right back up again.

Mr. DINGELL. Are there any provisions in the contract with regard to Federal Government for auditing by the intermediaries? Who is supposed to do auditing on these intermediaries?

Mr. KUSSEROW. They have an auditing function.

Mr. DINGELL. How extensive is their auditing? Is it effective?

Mr. KUSSEROW. They have an audit function that will be responsible for going out in the field to do on-site reviews. The problem we encountered there, Mr. Chairman, is that they weren't even looking at the excess credit balance. It wasn't in their "to do" or checklist. That is one of the things that we are very much concerned with. We think they should be looking at that.

As I mentioned earlier, some of these things have a tendency to fall out of sight. The audit trail sort of trails off. What you really want to do is get it on a regular basis. I suggested the intermediaries should look at this issue and document it. I think hospitals should be required on a quarterly basis to report the excess credit balances so we don't run the risk of losing it for the future.

Mr. DINGELL. Did you find any significant number of auditors that were required to be retained for the purposes of auditing the suppliers, or did you find that their auditors were nonexistent?

Mr. KUSSEROW. The auditors looked at the whole side of Medicare payments themselves. They are not going to go out to the suppliers and do things like that. They want to look at the cost reports, look at the payment system as it relates to Medicare in part A.

Mr. DINGELL. Did you find any evidence that the intermediaries had audited the suppliers in any fashion with regard to these overpayments?

Mr. KUSSEROW. We found virtually it was nonexistent in terms of examining it.

Mr. DINGELL. You found virtually nothing was done, then?

Mr. KUSSEROW. That's correct.

Mr. DINGELL. Did you find that they did anything, either the intermediaries or anybody else?

Mr. KUSSEROW. No. They did not find this a high priority area. They looked at the big cost and by comparison to the big costs, excess credit balances are peanuts.

Mr. DINGELL. Their idea was it was not to audit or to be accountable for it?

Mr. Kusserow, your estimate of $265.9 million to overpayments could be an overstatement, because some hospitals wrote off credit balances, is that correct?

Mr. KUSSEROW. That is only part of it. It is an understatement because we believe we may have lost a lot. When we looked at the current credit balances, we only looked at hospitals. This estimate

is only hospitals, 200 beds and above. It does not include those under 200 beds.

Mr. DINGELL. What you are telling me is they transferred money from accounts payable to Medicare to hospital revenues, is that right?

Mr. KUSSEROW. In many cases that is precisely what we encountered.

Mr. DINGELL. Has that ever been audited by HCFA?

Mr. KUSSEROW. No, it has not been for HCFA. The reports we did going back to 1986, at that time they were fairly aggressive in recovering all of the money we had noted, approximately $150 million, and they are trying now to collect it.

But the problem that I have with that whole process is that they really don't have a control mechanism to make sure the process is working without something falling off the table and out of sight. They need to have hospitals affirmatively coming forth with their excess credit balances, and they can reconcile that.

I need some sort of incentive for the hospital to do it. One would be, did they pay interest on the money they keep. They would have desire to move the money to Medicare or Uncle Sam, where it belongs.

Mr. DINGELL. I believe you found OMB got on HCFA and on the intermediaries on this matter because they said the scrutiny and audits and the actions of HCFA were violating the Paperwork Reduction Act, is that correct?

Mr. KUSSEROW. That's correct. When the hospitals complained that HCFA and intermediaries were asking them to report on a quarterly basis, they said, "You violated the process. You have to have prior approval from the Office of Management and Budget for approval."

Last November that process started, and we are waiting for OMB to approve this requirement under the Paperwork Reduction Act.

Mr. DINGELL. What you are telling me is that HCFA was auditing these people because they were taking moneys improperly, and these people went to OMB and between them they came up with the Paperwork Reduction Act as a way to bring the scrutiny by HCFA to a halt?

Mr. KUSSEROW. They weren't doing audits. They were telling them they must be reporting on a quarterly basis. Of course, OMB says, "That's a paperwork burden you are putting on people. You must clear that through us."

We are not sure OMB is against the Health Care Financing Administration doing this. They have to say, "You have to get our signature," and in the last few months they are trying to.

Mr. DINGELL. It would be hard to infer that OMB was in favor of the process.

Mr. KUSSEROW. Usually they are in favor of recovering that money.

Mr. DINGELL. They demonstrated quite a different attitude here.

Mr. KUSSEROW. It is peculiar, isn't it.

Mr. DINGELL. How much money was involved? Can you give us an idea?

Mr. KUSSEROW. As I mentioned, as of yesterday, they had recovered out of $260 million, $85 million, so they are collecting about

$10 million a month. They will slow down until we have had this process cleared and reinstituted, so you have the control. They are going after what we have identified. They have a quarterly reporting, and that's what we are waiting for approval for.

Mr. DINGELL. How long has OMB been sitting on it?

Mr. KUSSEROW. They have been studying this thing since November.

Mr. DINGELL. Nothing has happened because of the benign interest of OMB, is that right?

Mr. KUSSEROW. The OMB moves in mysterious ways. I am not sure what is going on there to predict it.

Mr. DINGELL. Can you give us an idea of which hospitals you found pocketing this money?

Mr. KUSSEROW. We have identified some hospitals that indeed have come out and have moved that money from the accounts receivable, where it can be seen for payment back to Medicare into their own arena.

Let me see if I can characterize it. If they say they wrote off that payable, that is a debt, the end result is you have a debit and credit situation. We have identified several hospitals where we can document that has happened.

Mr. DINGELL. Can you identify any particular hospitals affiliated with schools that were engaged in this practice?

Mr. KUSSEROW. Yes. This is far from complete, but in our own backyard we found Georgetown University has been writing off credit balances after just 90 days. If Medicare or the intermediary didn't swoop in on them 90 days later, it was scooped off the books.

Mr. DINGELL. How much money?

Mr. KUSSEROW. Only about $5,000 on the excess credit balance sheet.

What we did find—we also identified $1.2 million which was written off. We had to move that money into their own, if you will, revenue stream.

Mr. ROWLAND. Mr. Chairman, could I ask a question in reference to what you just said?

Mr. DINGELL. Could I ask a couple more questions, and I will be happy to yield. I want to get other schools and hospitals involved.

Can you tell us who was involved in this?

Mr. KUSSEROW. In Camden, N.J., our Lady of Lourdes Hospital.

Mr. DINGELL. Obviously a good charity.

Mr. KUSSEROW. We found they also had an excess of quarter of a million dollars, and had written off that debt to Medicare.

Mr. DINGELL. Who else?

Mr. KUSSEROW. Again, coming back to our neighborhood, Johns Hopkins.

Mr. DINGELL. How much with Johns Hopkins?

Mr. KUSSEROW. About 7,000. We are inclined to believe at this point—and I don't want to say for certain until we finish the process—but it looked like it might have been a clerical error. The amount was small.

We have two other hospitals that we are looking at where we can see this may have been happening, but we haven't been able to fully document the entire amount: Baptist Medical Center in South

Carolina, Spartanburg Regional Hospital in South Carolina. We don't have the dollar amounts.

Mr. DINGELL. Let me go down the list of hospitals. Yale-New Haven Hospital, is that right?

Mr. KUSSEROW. Yes.

Mr. DINGELL. How much were the total findings there? Your figure is $364,333, is that right?

Mr. KUSSEROW. If you would like to talk about hospitals where we found the greatest excess credit balances, I can go down from No. 1, or we can by whatever way you want to go.

Mr. DINGELL. I will yield to my good friend.

Mr. ROWLAND. Mr. Kusserow said something that I found interesting a moment ago. He said Georgetown in 90 days, if it wasn't getting some request for the return of the money, they just wrote it off, or wrote it in, however you want to look at it.

Let me ask you this: Doesn't HCFA have some procedures to require hospitals to report Medicare credit balances every quarter to intermediaries?

Mr. KUSSEROW. That's the point that the chairman was alluding to whereby when they started to implement that policy, there were complaints made they hadn't gone through the full procession with OMB on the Paperwork Reduction Act. They have to get approval to proceed with that process.

Mr. ROWLAND. It seems to me that would seriously impair the ability to recover money?

Mr. KUSSEROW. Yes.

Mr. ROWLAND. Do you have any idea how long you have to wait for OMB?

Mr. KUSSEROW. This is the last person in the world to try to predict that.

Mr. ROWLAND. What was the extent of the hospital attempting to repay funds to their intermediaries?

Mr. KUSSEROW. Most hospitals, in fact, made some overtures to try to pay back Medicare credit balance. The difficulty is we don't know whether it was a total accounting. We thought they were basically rebuffing. Nobody seemed to be ready to accept the payback.

Mr. ROWLAND. What excuses did they give in the hospitals?

Mr. KUSSEROW. They are too busy doing important things.

Mr. ROWLAND. Important things?

Mr. KUSSEROW. I don't know. As a matter of prospective, probably the most important thing in a relationship with some, if they owed you money, that would be a high priority to accept the check. They feel they have many big items where they are held accountable by the Health Care Financing Administration, and they put all that ahead and didn't have time left to accept checks and process.

Mr. ROWLAND. I would yield back.

Mr. DINGELL. You found this business of canceling and writing off moneys owed to the Federal Government by accident, did you not, really?

Mr. KUSSEROW. Yes—not by accident. We didn't expect to encounter this particular problem, because it is not a usual accounting practice.

Mr. DINGELL. It is also very hard to find?

Mr. KUSSEROW. Once you move the money out of the excess credit balance into some other area, the audit trail gets very, very hard to follow. It really intensified audit activity to retrace where it is. It is impossible——

Mr. DINGELL. The intermediaries you looked at were Blue Cross and Blue Shield of Connecticut?

Mr. KUSSEROW. Yes.

Mr. DINGELL. Blue Cross and Blue Shield of New Jersey, and Maryland.

Mr. KUSSEROW. Yes.

Mr. DINGELL. Blue Cross and Blue Cross of South Carolina?

Mr. KUSSEROW. Yes.

Mr. DINGELL. Blue Cross and Blue Shield of Wisconsin?

Mr. KUSSEROW. Yes. Do you want to skip the next one?

Mr. DINGELL. No. You go ahead and tell me.

Mr. KUSSEROW. Blue Cross and Blue Shield of Michigan.

Mr. DINGELL. What I was going to do was go through all of the Blue Cross and Blue Shield: Michigan, Oklahoma?

Mr. KUSSEROW. Yes.

Mr. DINGELL. You had Blue Cross and Blue Shield of California?

Mr. KUSSEROW. Yes. That is my home State.

Mr. DINGELL. I would note I have two columns: Total Findings, and Projection. In the case of Blue Cross and Blue Shield of Connecticut you have $1,600,000. Projection: $3 million.

What do those two figures mean and what is the difference between them?

Mr. KUSSEROW. The projected findings, that which we find in the excess credit balance account, and then the cumulative projection we feel is $3 million.

Mr. DINGELL. So the amount that is owed to the Federal Government is the difference between those two?

Mr. KUSSEROW. No. If you look at the total, if you were to project that out for the other hospitals that the intermediaries are responsible for, it comes up to a larger number.

Mr. DINGELL. In other words, that is the projection of the total number of hospitals which have moneys in this particular kind of account?

Mr. KUSSEROW. Yes. The first column is the actual hospitals that we looked at that were in the sample. The larger number is when that is folded in with the projection as to what it would be fiscal intermediarywide.

Mr. DINGELL. Do either of these moneys identify moneys owed to the Federal Government?

Mr. KUSSEROW. All of it.

Mr. DINGELL. Do any of these indicate moneys that are being written off by the intermediary?

Mr. KUSSEROW. Not on this. The fact is, all of the hospitals on there, we have individual audit reports. They have to pay back the money and they are not disputing the findings.

What I don't know, though, is I don't know whether in previous periods any money had been moved out or whether—it may not be complete.

Mr. DINGELL. That would be needed to go back in and find out how much was in fact moved out of these accounts at an earlier time not subject to the audit?

Mr. KUSSEROW. What you have here is what is there now.

I am not saying any of these hospitals did this. But let's say a hospital on this list moved this money off in previous periods, years back, especially during the period of time between collection efforts from our 1986 report to when we started this one. There may have been a period of time when they thought they could age out or they could drop off. I can't tell you what that is.

Mr. DINGELL. Did you find that the intermediaries permitted or did they participate in the writing off of these moneys?

Mr. KUSSEROW. No, they didn't do anything.

Mr. DINGELL. They sat idly by?

Mr. KUSSEROW. They sat there idly by, which meant some hospitals might have said, maybe we don't have to worry about it.

Mr. DINGELL. Let's look here at another question. Did you find that balances or credit balances with commercial insurance companies were also written off?

Mr. KUSSEROW. That is not something within our jurisdiction to establish. It was clear when we looked at excess credit balances that a large number, or large dollar volume, also existed that was owed back to insurance companies and for the same reasons. That is, an insurance company as with Medicare might have been accidentally billed twice for the same service or a service not rendered, and they had an excess credit balance because they realized there was a mistake. I would say there is a lot of money out there that private health insurers have owed to them.

Mr. DINGELL. So this is not something limited just to Medicare but quite possibly, or quite probably, something which affected commercial insurance companies and holders of commercial insurance policies; is that right?

Mr. KUSSEROW. It is suggestive of that. What I really don't know is how aggressive the private insurance industry has reflected credit balances. There is a significant sum of moneys at these hospitals that belongs to insurance companies.

Mr. DINGELL. Mr. Kusserow, doesn't Medicare require hospitals to identify payback of this money?

Mr. KUSSEROW. Yes.

Mr. DINGELL. Did the hospital decide it was just income to the hospital?

Mr. KUSSEROW. They shouldn't.

Mr. DINGELL. There are both statutes and rules and regulations that do require this money to be paid back.

Mr. KUSSEROW. They know that.

Mr. DINGELL. Can you tell me whether this is a fraud or not?

Mr. KUSSEROW. It really depends on whether it is a willful attempt to avoid ever paying that money back. That's why I said in addition to the audit work we have done, we have been screening all 57 of the audits and working papers to see if there is evidence in the working papers that would suggest there was a malice or willful side of this, in which case that changes the ball game.

Mr. DINGELL. Mr. Kusserow, you said there are other reasons why your projections are low and why the problem is bigger. The

first situation is because you were only able to look at a small percentage of the number of hospitals; is that right?

Mr. KUSSEROW. Albeit they were the larger ones, that is quite right. The majority of the hospitals are not included in this projection.

Mr. DINGELL. Are there other reasons why these numbers are wrong or unrealistically low?

Mr. KUSSEROW. Yes. What we really don't know is whether in prior periods, because this is a cumulative number, we don't know whether money will be written off in one form or another.

There is one other thing I would add: What we are seeing here is uncorrected. We have an incline here where the cumulative credit balances are growing and continuing to grow, and there will be a larger problem.

Mr. DINGELL. You said they disguise credit balances?

Mr. KUSSEROW. Yes.

Mr. DINGELL. They are no longer included with other patient account receivables; is that correct?

Mr. KUSSEROW. Yes.

Mr. DINGELL. What steps has the auditor taken to recapture these items?

Mr. KUSSEROW. It is very, very difficult if you are going to go back into prior periods where money may have been shifted off of the credit balance sheets and gets moved into some other account area. That would take a very, very intensified effort.

What we have done, to see if we could scope out the problem, at Capitol Hill Hospital, to see how much effort it would take to get behind the numbers, and it tells us that an area—if there is sufficient resource available to invest time and effort to get that money.

Mr. DINGELL. In this pilot study which you conducted, did you find overpayments in other accounts also?

Mr. KUSSEROW. Yes. What we found is that by reviewing the closeout accounts in the miscellaneous income accounts, that we could identify about $200,000 to this one hospital that really belonged to Medicare.

Mr. DINGELL. $200,000?

Mr. KUSSEROW. Yes.

Mr. DINGELL. Did you find overpayments in many accounts, or diversified accounts, or single accounts?

Mr. KUSSEROW. We found a variety of things that had occurred. It was not one of these things where everything was being shifted all over the place. There was a lot of shifting that had gone on that was inappropriate. There was no willfulness there we could establish. It does tell us it is sloppy accounting, and it did not benefit Medicare or harm Medicare. They will make restitution to what is owed Medicare.

Mr. DINGELL. You reviewed a lot of accounting records of hospitals. What ones were reviewed in the pilot study that gave rise to the detection of Medicare overpayments?

Mr. KUSSEROW. We focused our efforts on the excess credit balances. Again, what we were looking for there are situations whereby you track a patient's records that would indicate the patient had been billed twice for the same service and create a duplicate payment that was owed back to Medicare.

We would find situations where, in looking again at the patient records, a procedure had been called for. In fact, it had never been delivered, but it was something that moneys—because the service had not actually been performed. So we found by reconciling by that end of the process, we could verify that which had been duplicated or that which had been billed to Medicare in the first place.

Mr. DINGELL. Apparently the auditing of a hospital is very complex and difficult. I suspect it requires a fairly good number of auditors, real time activity with regard to the events that are occurring at the hospital, but also a clear plan of auditing.

Are those statements correct?

Mr. KUSSEROW. All the statements are correct.

Mr. DINGELL. Is there anything else you had to put into a hospital audit to see if they are behaving properly?

Mr. KUSSEROW. There are an infinite variety of things. The intermediary auditors, they look at big items like maybe indirect medical education cost issues; those are very big issues.

One area that clearly warrants better understanding is the area that you had asked us to look at, which we are in the process of doing, which is analogous to what we had done with universities. Those are services and costs not related to patient care.

So we do think there are an awful lot of things going on to a better understanding on that that are beneficial.

Mr. DINGELL. I would like to have you tell us this: Did you find they had, either the intermediaries or HCFA or HHS, had a sufficient number of auditors?

Mr. KUSSEROW. In fact, we certainly appreciate the attention you give to our audit work, but we feel a stress when we do these major jobs. We have one auditor for about $100 million outlays in our network.

Mr. DINGELL. You are talking about the inspector general?

Mr. KUSSEROW. That's correct.

Mr. DINGELL. I am curious about HHS. What is the auditing competence with regard to the accounts that we are discussing here?

Mr. KUSSEROW. All of the auditors of HHS are basically in our office.

Mr. DINGELL. You folks were the only ones doing these audits?

Mr. KUSSEROW. Yes.

Mr. DINGELL. No one else was doing them?

Mr. KUSSEROW. What I had alluded to earlier, the contractors, the fiscal intermediaries have an audit function built into their contract. Whether it is FDA or Social Security, or whether it is in the Health Care Financing Programs or in Headstart or in Indian Health Service, it is the 700 auditors in our office that do it.

Mr. DINGELL. You have given me very, very little comfort that there is adequate auditing effort at the HCFA or HHS.

Mr. KUSSEROW. We are the HCFA auditors. If the HCFA auditors are doing a bad job, I apologize.

Mr. DINGELL. You are telling me HCFA did virtually no auditing?

Mr. KUSSEROW. We are the auditor for HCFA.

Mr. DINGELL. Did you tell me how many you had?

Mr. KUSSEROW. 700. We are going down. We are reducing our staff.

Mr. DINGELL. I want to get into a cost/benefit study. We intend to go into that cut.

Mr. KUSSEROW. I will be happy to give you that. The payback is $67 for every dollar put into the effort.

Mr. DINGELL. Tell me this, Mr. Kusserow, what kind of auditing efforts did you find by the intermediaries? Anything?

Mr. KUSSEROW. As I mentioned, they were looking at the big-ticket items, like capital. This sort of fell between the cracks.

I quite frankly think that one of the problems for the intermediary audit function is really the realization that there are responsibilities that have shifted with the advent of prospective payments.

It used to be that paying all the necessary charges, a retrospect, a major responsibility of these fiscal intermediaries were to audit the cost reports and make sure the cost reports were true and correct. But as we now move away from paying those costs reports to this payment system, that is beginning to disappear; the audit has to change as well. A good place we give additional focus is in this area.

Mr. DINGELL. What you are describing to me is not auditing?

Mr. KUSSEROW. Somebody is reviewing both in terms of a desk review of the cost reports as well as on field reviews at the certain sites. If you are saying a routine, yes.

Mr. DINGELL. Sitting at a desk and pushing buttons on a computer?

Mr. KUSSEROW. Yes, a lot of it.

Mr. DINGELL. A lot of it is not done by looking at the books?

Mr. KUSSEROW. Probably not nearly enough.

Mr. DINGELL. The intermediaries aren't doing much auditing then, are they?

Mr. KUSSEROW. They are doing a lot. The question is whether they are putting the resources where it has the best effect.

Mr. DINGELL. Not the accounts we are referring to now, though?

Mr. KUSSEROW. The general feeling is this is really small peanuts.

Mr. DINGELL. What are the requirements that are in the contracts with the intermediaries with regard to auditing the accounts that they are so busily paying?

Mr. KUSSEROW. Again, they will put their resources where there is a heavy value, point value, in terms of being written evaluation as part of their performance. What you don't have included in that is this area, so therefore, they are not as likely to be very much interested.

We found the fiscal intermediaries are equally disinterested in this area, because it doesn't really matter to them. If it would affect their contract renewal, then I think they would pay a little more attention. I think the hospitals would pay more attention and pay back the money if they were going to be charged interest for the money they were holding that belonged to Medicare.

I think there needs to be some internal controls put into the system to make sure these excess credit balances—they will catch when this money is moving in and out, to make sure it is properly reconciled.

Mr. DINGELL. I recognize the gentleman from Georgia.

Mr. ROWLAND. Thank you, Mr. Chairman.

Let me depart a little bit and ask you about a study that was asked you to do, so-called indirect study. You have expanded that because of the initial findings that you had. Are you going to be ready to testify on this in mid-June?

Mr. KUSSEROW. Yes; we said we would be prepared at that time. What we did look at are the G&A indirect cost pools at certain hospitals, and examine fringe benefits.

Again, the task was described in terms of trying to determine whether hospitals are operating at a bare-bones kind of environment. Their backs are up against the wall because of a funding crisis. We wanted to look at that.

We began to look at the hospitals that were requested by the subcommittee. We found enough there to cause us some concern, and we felt we needed to have a much larger sample of hospitals.

Mr. ROWLAND. What were the initial hospitals?

Mr. KUSSEROW. Allied Services in Scranton, PA; Moss Rehabilitation and Einstein Hospital in Philadelphia; and Humana Hospital in San Antonio.

We did find expenditures that individually did not—that were explainable. It was a question of judgment: In aggregating it, we saw there was a lot of money that would contradict the notion that they were operating under distress conditions. If we were operating under distress conditions, we would not find it.

We tried to find out whether these hospitals were representative of a larger number, so we decided to draw an additional 15 hospitals to look at the same thing to see whether the 4 hospitals were representative of a larger number. In addition to that, we are taking a much larger examination and broader context to see whether there is more out there that we should understand.

Mr. ROWLAND. You are auditing different hospitals for profit and not?

Mr. KUSSEROW. Yes; so we are not focusing on one type of a hospital.

We also wanted to look at hospitals that were participating under the prospective payment system as well as those under the retrospective cost payment system, to see if there is a difference between the two.

Mr. ROWLAND. Are you finding similar charges at each hospital?

Mr. KUSSEROW. It is a little early to come back. We certainly have not found expenditures that were similar to the kind of things that were found when the subcommittee had us look at Stanford University. At Stanford, we had grants and contract costs charged to the Federal Government.

Hospitals under the prespective payment system are different from schools. In fact is like a fixed-rate contract. If they are wasting money not related to patient expenses, then the hospitals are hurting themselves.

Then the question comes up to the question the committee Chair had raised in his opening remarks about when hospitals come in and talk about whether they are really distressed financially because of Medicare, whether in fact they are distressed, if they can make these kind of expenditures. We are finding a lot that are questionable.

I think you will find as interesting the information in the aggregate as you would the individual examples which sound peculiar.

Mr. ROWLAND. I guess in the nature and the extent of the charges, we should review what should or should not be allowable and reasonable under the existing payment structure to see whether it is artificially inflated. Would you agree with that?

Mr. KUSSEROW. There are two things. On a cost reimbursement basis, I think you should question what should be charged to Medicare.

I think the problem presented to you folks in Congress is what effect would the information that you are getting have on you when you consider the updating of the prospective payment rates, and whether when you hear evidence that certain increases are meritorious because of the financial stresses that hospitals say they are operating under in the current climate, how much credibility that has against what you are seeing in the reports we produce.

I really can't be judgmental and say what we are finding is good or bad. I will just give you information and hopefully based upon the information that we give, by the time we get it, it will give you enough that will help guide you a little bit.

Mr. ROWLAND. It certainly will be an interesting study, and we will look forward to seeing the results in June.

Thank you, Mr. Chairman.

Mr. DINGELL. You have been most helpful to the committee, we thank you very much for your assistance. Thank you very much.

Mr. KUSSEROW. Thank you.

Mr. DINGELL. The next witness is Frank Reilly, Director of Human Resources Information Systems, Information Management and Technology Division, U.S. General Accounting Office, Washington, DC.

Do you have associates you would like to have at the witness table with you? We will be honored to have them join you, and we will proceed with the qualification.

Mr. Reilly, as you know, the requirements of this committee is that all witnesses before this subcommittee testify under oath. Do you or your associates have any objection to testifying under oath?

Mr. REILLY. No, sir.

Mr. DINGELL. The chairman advises you that you can be advised by counsel. Do you wish so?

Mr. REILLY. No.

Mr. DINGELL. Copies of the rules of the committee, the subcommittee, and House are there at the witness table before you to inform you of your rights and the limitations of the powers of the subcommittee.

Could you give us the name of your associate, please?

Mr. REILLY. Mr. Thomas Dowdal.

Mr. DINGELL. Welcome to the committee. Are you going to testify or just assist Mr. Reilly?

Mr. REILLY. I will testify, and if we have any questions I can't handle, Mr. Dowdal can.

Mr. DINGELL. If this meets your approval, we will swear you both. If you will rise and raise your right hands, gentlemen.

[Witnesses sworn.]

Mr. DINGELL. You may consider yourselves under oath.

Please identify yourselves for the record. We will recognize you for such statements you choose to give.

TESTIMONY OF FRANK REILLY, DIRECTOR, HUMAN RESOURCES INFORMATION SYSTEMS, INFORMATION MANAGEMENT AND TECHNOLOGY DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY TOM DOWDAL, ASSISTANT DIRECTOR, HUMAN RESOURCES DIVISION

Mr. REILLY. I am Frank Reilly, Director, Human Resources Information System, General Accounting Office.

Mr. DOWDAL. Tom Dowdal. I am Assistant Director in the Human Resources Division in charge of the Medicare area.

Mr. DINGELL. I will thank you both for being here. You will be recognized for your statement.

Mr. REILLY. If I may, I would like to summarize my statement.

Mr. DINGELL. Without objection, your full statement will appear in the record and we will recognize you for any summary you wish to give.

Mr. REILLY. After listening to the testimony of Mr. Kusserow, I think it might be useful to start off by stressing the sheer size of this program that presents many of the problems you heard this morning and many we are going to discuss.

The program in 1991 was $108.5 billion. If you look at 250 working days, that is 2 million transactions a day and $400 million in payments. So by any standard——

Mr. DINGELL. Per day?

Mr. REILLY. $400 million per day.

The Medicare Program would fit into the 10 largest businesses in this country. It is bigger than most people realize. You heard this morning, HCFA has Medicare claim contractors to perform the processing. These processing contracts are considered an administrative cost. These costs run somewhere between 1 and 2 percent of the total claims. That is the total cost of processing of the claims.

HCFA, being concerned about these administrative costs, decided to start a shared system policy. By that, I mean they wanted to reduce the administrative costs of the multiple software and computer processing systems that the contractors used to process all these 500 million claims a year. They wanted to introduce uniformity in sharing both software and computer processing.

I think it is fairly obvious to anybody that with this size of volume, there is only one way to basically handle it, and that is by computer systems. So the contractors essentially run gigantic computer systems.

We took a specific look by evaluating five processing sites. In addition, we sent questionnaires to all of the intermediaries, and most of them responded. From the data we collected to date, we concluded the following: That prior to initiating this shared systems policy, HCFA failed to conduct a study to determine the most successful claims processing programs. That is a very basic problem.

The second conclusion is they failed to establish any processing standardization criteria until after the policy was implemented.

The third major problem was they failed to recognize the impact of the shared system policy on total costs. So in some respects you seem to have a situation where the administrative cost, the tail is wagging the large program cost dog. As a result, a critical analysis of total program cost has tended to get lost in the shared system policy.

What it means is the administrative savings projected may be offset by millions of dollars in Medicare Program costs added during the conversion.

Specifically, we found during this conversion period Blue Shield of California overpaid nearly $33 million during the conversion period. Nationwide Insurance of Ohio made about $7.2 million in overpayments. Blue Cross of South Carolina made overpayments of $900,000, and Blue Shield of Michigan made overpayments of $1.1 million.

In addition, we received informal information—and this particular amount of money is not in the report—that Blue Cross of California, which is a part A contractor, estimated they lost about $40 million during conversion.

When I say "lost," what I am talking about is comparing the program costs before the conversion period and during the conversion period. If you look at the numbers 6 months before and the 6 months after, this is where you come up with these numbers.

We support a planned shared system policy. I want to really stress that, from a management standpoint, the General Accounting Office supports a shared system policy. But we recommend that HCFA suspend further implementation of this policy until the deficiencies we identified are addressed.

The long-range plan is dealing with those savings in the processing area. As I said in my initial few sentences, this is an enormous problem because of the $100 billion size of the program, and what you require here is a well-thought-out management approach. Any action you take with something this large can have an effect, either positive or negative.

If you don't plan it well in advance, it may do the opposite of what you intend. I think that summarizes our testimony.

[Testimony resumes on p. 91.]

[The prepared statement and attachment of Mr. Reilly follow:]

STATEMENT OF FRANK REILLY

Mr. Chairman and Members of the Subcommittee:

I am pleased to participate in the Subcommittee's hearings on the Health Care Finance Administration's (HCFA) Medicare program. As you know, HCFA contractors processed over half a billion transactions representing $108 billion in Medicare claims in fiscal year 1991. Because of the complexity and magnitude of the Medicare program, these contractors rely extensively on automated data processing (ADP) systems to review medical services and determine if claim payments are justified. I will be talking today about HCFA's approach in implementing a major initiative that encouraged contractors to share ADP systems with other contractors.

HCFA implemented this initiative--the shared systems policy--in January 1989 to reduce the administrative costs of maintaining multiple systems and to promote uniformity.[1] However, although HCFA estimates that its shared systems policy will save about $16 million through fiscal year 1992, these savings may be offset by millions of Medicare program dollars lost during conversion. The issues I am discussing are described in greater detail in our report Medicare: Shared Systems Policy Inadequately Planned and Implemented (GAO/IMTEC-92-41, March 18, 1992), which is being issued today.

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[1]HCFA believes that by reducing the number of ADP systems and having multiple contractors share one system, processing operations will be easier to standardize and maintain.

Both we and the Department of Health and Human Services' Inspector General have identified Medicare payment problems that have resulted in millions of dollars in overpayments. Our review of HCFA's shared systems policy raises concerns about how effectively HCFA manages and monitors contractors' systems that make these payments. HCFA implemented this policy without adequate planning and provided little or no oversight during policy implementation. For example, HCFA did not establish minimum automation requirements to ensure that claims would be processed efficiently and accurately. Without such requirements, HCFA had no criteria by which to evaluate individual contractor systems. Such an evaluation is essential to identify and select the best systems for sharing with other contractors. Further, in developing its policy HCFA focused primarily on administrative savings, ignoring the effect that ADP systems have on Medicare claims-processing effectiveness. Finally, HCFA encouraged contractors nationwide to comply with its policy without first defining a long-term automation strategy.

SYSTEMS REQUIREMENTS NOT DEFINED AND EVALUATION OF CONTRACTOR SYSTEMS INADEQUATE

One of the first steps in initiating a major system change should be to identify and document minimum automation or functional requirements to support mission needs. In the case of HCFA, these requirements would provide contractors with specific claims

functions and program controls that should be performed by shared systems. For example, the requirements would establish data standards to ensure that claims are processed in a consistent manner. The requirements would also describe the minimum number and types of computer screens and edits needed to review Medicare claims.[2]

Despite the essential need for early planning, HCFA did not develop a list of minimum automation requirements for Medicare part A until January 1991, almost 2 years after instituting the shared systems policy. Only recently, in January 1992, did HCFA develop requirements for Medicare part B.[3] By the time these requirements had been defined, the majority of contractors had already converted to shared maintenance or processing systems arrangements.

HCFA also did not perform system evaluations before implementing its shared systems policy. Such evaluations are needed in order to assist contractors in identifying the most appropriate systems for sharing. In 1991 HCFA performed a post-conversion evaluation of the six systems that shared ADP arrangements for Medicare part A. We analyzed these evaluations and found that none of the six

[2]Contractors use screens and edits to review claims for coverage, unnecessary procedures, and other factors that may make payment unwarranted.

[3]HCFA currently has requirements for 10 major categories, including data collection and validation, reporting, file maintenance, correspondence, and claims adjudication.

systems fully met HCFA's minimum automation requirements. For example, five of the systems did not have adequate computer screens with which to review for duplicate claims.

In the absence of system evaluations, contractors were generally left on their own to decide which other contractors' systems to share. Failure to select the right system resulted in costly claims-processing problems. For example, we estimated that Blue Shield of California overpaid nearly $33 million in Medicare part B payments during the 6 months following its conversion to a shared system.[4] Specifically, before the contractor entered into a shared systems arrangement, its system had about 200 computer screens to review Medicare claims. These screens review claims to detect unnecessary and uncovered procedures and erroneous and duplicate payments. After switching to another contractor's system, the company lost 75 of these computer screens. We also estimate that Nationwide Mutual Insurance Company, another HCFA contractor, may have made about $7.2 million in Medicare overpayments during its conversion period. Nationwide's vice president said the new system initially failed to identify all duplicate billings and that certain edit screens were shut off to reduce processing backlogs, resulting in more overpayments.

[4]We compared Medicare payments denied per claim processed for seasonally comparable periods before and after conversion and projected the overpayment by multiplying the difference per claim by the number of claims processed in the post-conversion period.

In addition, many contractors experienced claims-processing disruptions and reduced productivity during conversion to shared systems. Of the 34 contractors who converted to shared ADP systems in fiscal years 1989 and 1990 (40 percent of all contractors), all had problems in at least one of the following three areas: decreased program safeguards, increased interest payments, and increased payment errors. For example, Blue Cross of South Carolina and Blue Shield of Michigan both lost an automated feature that helped them identify when a Medicare patient had other insurance coverage. We estimate that the loss of this feature may have resulted in overpayments of $951,000 for Blue Cross of South Carolina and $1.1 million for Blue Shield of Michigan during the 6 months following conversion.

HCFA did not consider the impact that system conversions would have on Medicare payment activity. Instead, the agency performed a limited analysis, comparing the systems' conversion costs to estimated administrative savings. HCFA's shortsighted focus on administrative savings, while ignoring systems impact on the Medicare program, has jeopardized the ADP systems' effectiveness in safeguarding the hundred-billion-dollar Medicare program.

HCFA HAS NOT DOCUMENTED OR COMMUNICATED ITS LONG-TERM SYSTEMS PLAN

Although HCFA will have spent $39.6 million through fiscal year

1992 in implementing the shared systems initiative, it has done so without a long-term systems plan or vision for the future. In effect, HCFA has not formally examined how best to process Medicare claims given current technology, but rather decided merely to reduce the number of ADP systems used. A long-term plan would identify the types of systems HCFA eventually hopes to have in place to best process claims given the state of ADP technology. This plan would also provide contractors with a better understanding of how HCFA envisions its future contractor ADP operations. The lack of such a plan has left contractors to speculate on how HCFA's ADP operations will evolve.

Moreover, HCFA has been considering further changes in its shared systems policy. In a December 1991 memorandum to all contractors, HCFA made it clear that shared processing, rather than shared maintenance, is the preferred systems arrangement. HCFA stated that it would provide additional funding for claims-processing improvements only to contractors in shared processing arrangements. HCFA has specified that its goal is to determine the optimal number of shared systems arrangements that would provide the lowest possible administrative costs to maintain. This may require further conversions. HCFA has not yet established, however, that additional conversions would be cost-beneficial.

We support the concept of shared systems that are properly

planned and implemented. However, we are concerned that if HCFA does not improve its implementation of this policy by better evaluating its needs, identifying options, and developing a strategy and plan to improve claims-processing efficiency and effectiveness, then millions of additional Medicare dollars may be wasted.

We are recommending that HCFA suspend further implementation of its shared systems policy until the deficiencies we have identified are addressed.

Mr. Chairman, this concludes my statement. I will be glad to answer any questions you or other Members of the Subcommittee may have.

GAO
United States
General Accounting Office
Washington, D.C. 20548

Information Management and
Technology Division

B-247927

March 18, 1992

The Honorable John D. Dingell
Chairman, Subcommittee on Oversight
and Investigations
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we provide the results of our review of a 1989 Health Care Financing Administration (HCFA) policy change that encourages HCFA's Medicare claims-processing contractors to share automated data processing (ADP) systems. In fiscal year 1991 HCFA paid 85 contractors $1.4 billion to process over half a billion Medicare claims. HCFA implemented the shared automation policy to save administrative costs and promote uniformity. This report presents our evaluation of (1) HCFA's implementation of this policy change and (2) the policy's impact on Medicare claims processing. Further details of our review objectives, including our scope and methodology, are provided in appendix I.

RESULTS IN BRIEF

While the shared automation initiative may save millions of dollars in administrative costs, these savings may be offset by millions of Medicare program dollars lost during conversion. Much of this loss results from problems in the way HCFA implemented its policy change. In particular, HCFA implemented this policy without adequate preparation and provided little or no oversight during its implementation. Further, HCFA did not establish minimum automation requirements to ensure that claims would be processed efficiently and accurately until 2 years after implementing the policy. Lacking these systems requirements, HCFA had no criteria with which to evaluate individual contractor systems. Such evaluation is needed to identify and select the best systems for sharing with other contractors. As a result, contractors stopped using their own systems and began using other systems that may have been less effective.

The cost-effectiveness of requiring all contractors to enter into shared ADP arrangements has not been demonstrated. In developing this initiative, HCFA focused primarily on administrative savings, ignoring the effect ADP systems have on processing effectiveness. Many contractors experienced claims-processing disruptions and reduced productivity during conversion to shared ADP systems. In addition, although HCFA has not adequately defined a long-term strategy for contractor systems, it is considering requiring additional changes to its shared systems policy, without determining whether such changes would be cost-beneficial.

BACKGROUND

Medicare is a federal health insurance program that covers over 30 million Americans 65 years of age or older, and others under age 65 with disabilities or chronic kidney disease. HCFA, an agency within the Department of Health and Human Services, pays contractors to process the payment of bills and claims and otherwise administer the program. Medicare part A (Hospital Insurance) covers services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities. Medicare part B (Supplementary Medical Insurance) covers physicians' services and a range of other noninstitutional services, such as diagnostic laboratory tests and X rays.

HCFA employs contractors to process more than half a billion Medicare claims annually. These contractors, Blue Cross and Blue Shield plans or commercial insurance companies, rely extensively on ADP systems because of the complexity and magnitude of the program. These systems help contractors review medical services and determine if the claim payments are justified. Contractors use computer edits and screens to identify claims for services that are not covered under Medicare, claims that should be paid by primary insurers rather than the government, or otherwise appear questionable. For example, a screen could identify physician hospital visits that exceed guidelines for medical necessity and may not warrant payment.

SHARED SYSTEMS POLICY: DESCRIPTION AND STATUS

In January 1989 HCFA had 87 contractors (50 part A and 37 part B) using 58 different ADP systems to administer the Medicare program.[1] In fiscal year 1989 HCFA paid these contractors about

[1]Thirty-nine of the 87 contractors shared ADP systems, while the remaining 48 operated and maintained their own individual systems.

$1.2 billion in administrative costs, including almost $270 million to operate and maintain individual ADP systems. Medicare program changes often required making software modifications to all 58 ADP systems and HCFA incurred significant administrative expense paying for these modifications.

To reduce the administrative costs of maintaining multiple systems and to promote uniformity,[2] HCFA in January 1989 implemented a policy that encouraged more contractors to share Medicare ADP systems. It asked contractors to make plans to share ADP maintenance or processing with other contractors. This could be accomplished if two or more contractors agreed to (1) share ADP maintenance[3] by keeping separate computer operations but using the same software, or (2) share processing by consolidating computer operations--both hardware and software--into a single system. HCFA agreed to pay the contractors the costs of converting from their individual systems to shared maintenance or processing arrangements.

Compliance with HCFA's policy change was voluntary. However, to encourage participation HCFA informed contractors that it would no longer pay all costs to operate and maintain individual systems if contractors did not convert to a shared systems arrangement. HCFA held the contractors responsible for analyzing other contractor systems and selecting the best systems arrangement for the Medicare program. The agency did not provide specific guidance beyond a list of systems that were already operating in a shared systems arrangement.

As of January 1992, contractors had reduced the number of ADP systems processing Medicare claims from 58 to 22--14 shared systems, 6 for processing part A and 8 for processing part B, and 8 individual systems.[4] HCFA's estimated costs for converting contractor systems and the associated savings for fiscal years 1989-1992 are shown in table 1.

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[2]By reducing the number of ADP systems and having multiple contractors share one system, HCFA believes processing operations will be easier to standardize and maintain.

[3]System maintenance refers to work performed by a contractor to change or update claims-processing software.

[4]Seventy-three contractors were using these shared systems, including 46 contractors in shared maintenance arrangements and 27 in shared processing. Shared systems processed 87 percent of the part A claims and 75 percent of the part B claims in fiscal year 1991.

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Table 1: HCFA's Estimates for Costs and Savings for Shared Systems
(Dollars in millions)

	1989	1990	1991	1992[a]	Total
ADP Costs	269.0	299.0	323.0	337.0	1,228.0
Conversion Costs	2.0	13.0	13.6	11.0	39.6
Shared System Savings[b]	8.1	8.8	30.8	7.8	55.5
Net Savings or Loss[c]	6.1	[-4.2]	17.2	[-3.2]	15.9

[a] Fiscal year 1992 data are budget data because actual data are not available.
[b] HCFA determined these savings by comparing the actual shared systems maintenance costs with an estimate of what the maintenance costs would have been if the systems had not been consolidated. Additional savings in 1991 were achieved because HCFA reduced the ADP budgets of contractors using individual systems as an incentive to enter into shared arrangements. Despite savings, ADP costs continued to increase because of legislative changes requiring significant system enhancements.
[c] Shared systems savings minus conversion costs. Net savings do not reflect the cumulative impact of prior year savings.

SYSTEMS REQUIREMENTS NOT DEFINED AND EVALUATION OF CONTRACTOR SYSTEMS INADEQUATE

HCFA implemented the shared systems policy without defining minimum automation requirements to ensure that claims would be processed efficiently and accurately. One of the first steps in initiating a system change should be to identify and document minimum automation or functional requirements to support mission needs.[5] In the case of HCFA, these systems requirements should consider how the Medicare program's information needs could best be supported by automation. The minimum system requirements would have provided contractors with specific claims functions

[5]Information Technology: A Model To Help Managers Decrease Acquisition Risks (GAO/IMTEC-8.1.6, August 1990).

and program controls that should be performed by the shared system. For example, the requirements would establish data standards to ensure claims processing consistency and describe the minimum number and types of computer screens and edits needed to review Medicare claims.[6] It would also describe system reporting capabilities, including daily and weekly processing activities and monthly management reports.

HCFA did not evaluate individual contractor systems in order to identify the most appropriate systems for sharing with other contractors. Contractors were generally left on their own to decide which other contractors' systems to share. For example, Blue Cross of South Carolina identified its own set of systems criteria to evaluate potential systems as candidates for a shared systems arrangement.[7] While Blue Cross of South Carolina had some conversion problems, the vice president of Medicare operations indicated that establishing systems evaluation criteria was beneficial in helping them select a shared systems arrangement that met their needs.

Failure to select the right system resulted in costly claims-processing problems for some contractors. For example, Blue Shield of California did not establish systems criteria or evaluate potential shared systems arrangements and, as a result, the shared systems arrangement selected did not have as many automated features as the system it replaced. In the 6 months following its conversion to a shared system in August 1990, we estimate that Blue Shield of California overpaid nearly $33 million under Medicare part B.[8] Specifically, before the

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[6]Contractors use screens and edits to review claims for coverage, unnecessary procedures, and other factors that may make payment unwarranted.

[7]Blue Cross of South Carolina developed a 32-item list of criteria that they wanted in a shared system. Criteria included HCFA reporting requirements, maintenance arrangements, number of staff required, and home health claims processing since they are one of only nine regional home health contractors.

[8]We analyzed HCFA data for 34 contractors who converted from their own ADP system to a shared systems during fiscal years 1989 and 1990 to identify the impact of conversion on contractor performance. We compared Medicare payments denied per claim processed for seasonally comparable periods before and after conversion and projected the overpayments by multiplying the difference per claim by the number of claims processed in the post-conversion period. HCFA officials agreed that this methodology was reasonable for projecting overpayments.

contractor entered into a shared systems arrangement, its system had about 200 computer screens to review Medicare claims; after switching to another contractor's system, the company lost 75 of these computer screens. These screens review claims to detect unnecessary and uncovered procedures and erroneous and duplicate payments. The Blue Shield of California vice president for Medicare operations stated that his company had not done an analysis to estimate the amount of Medicare overpayments during the conversion period.

Similarly, the vice president of Medicare operations at Nationwide Mutual Insurance Company, another HCFA contractor, said it experienced similar problems after converting to the same shared system. We estimate that Nationwide made about $7.2 million in Medicare overpayments during the conversion period. The vice president said Nationwide has not analyzed overpayments for the conversion period. The vice president said the new system initially failed to identify all duplicate billings and to avoid processing backlogs, certain edit screens were shut off, resulting in more overpayments.

Despite the critical need for early identification and evaluation of shared system requirements, HCFA did not develop a list of minimum automation requirements for part A until January 1991, almost 2 years after instituting the shared system policy.[9] By December 1990, just prior to HCFA's making part A requirements final, 41 part A contractors were operating in a shared arrangement. At that time only 8 part A contractors were still using individual systems. HCFA has only recently, in January 1992, developed minimum automation requirements for part B. By the time these requirements had been defined, the majority of contractors had already converted to shared maintenance or processing systems arrangements.

On the basis of the defined minimum automation requirements for part A, HCFA in 1991 performed an evaluation of the six systems being shared. We analyzed these evaluations and found that none of the shared systems fully met HCFA's minimum automation requirements. For example, five of the systems did not have adequate computer screens with which to review for duplicate claims, and none of the six met all report requirements. On average these shared systems failed to adhere to about 20 percent of the minimum automation requirements, according to HCFA's project leader. HCFA plans to require part A contractors to

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[9]HCFA issued requirements for ten major categories, including data collection and validation, reporting, file maintenance, correspondence, and claims adjudication.

correct any identified system deficiencies and may require them to pay for the corrections themselves.

In response to a questionnaire we sent in July 1991, only 20 of the 55 contractors in a shared maintenance or processing arrangement indicated they were very satisfied with their shared systems and that operational efficiency had improved.[10] Seventeen contractors indicated that they experienced processing problems during conversion, and the remaining 18 contractors indicated that either system upgrades were still needed to correct deficiencies or that they had seen no improvement in their operational efficiency and thought that conversion costs outweighed the benefits.

COST/BENEFIT ANALYSIS INADEQUATE

HCFA did not perform a comprehensive cost/benefit analysis on the impact of the shared systems policy. The agency performed a limited analysis, comparing the systems conversion costs with estimated administrative savings. HCFA believes that maintaining fewer systems and processing centers can reduce costs and promote uniformity. However, it did not consider the effect conversions may have on Medicare payments, including the differing systems' capabilities such as edits and screens, for ensuring Medicare payment accuracy.

Cost/Benefit Analysis Did Not Consider Management Data

In acquiring automated information systems, federal regulations and guidance require a complete and supportable cost/benefit analysis that provides adequate information with which to analyze and evaluate alternative approaches.[11] These analyses provide management with information on the quantifiable and nonquantifiable costs and benefits of alternative approaches to solving a given problem, which should then enable managers to determine the best alternative for achieving agency objectives.

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[10]We sent questionnaires to 83 contractors and received 74 responses. Sixty-three contractors were in a shared maintenance or processing arrangement. Fifty-five of the 63 contractors responded to this particular question.

[11]Federal Information Processing Standards Publication 64 and FIRMR 201-20.

HCFA maintains management data, submitted by the contractors, on claims-processing activities and performance measures. For example, contractors report the number and dollar amounts of claims denied due to other private insurers' being responsible for payment or the services not being covered under Medicare guidelines. HCFA also maintains data on claims-processing errors and interest paid to beneficiaries and providers for payments that were not made within established time frames. HCFA's program managers review these data to evaluate contractor performance and health care trends to identify needed changes in program policy and coverage.

HCFA systems analysts did not review these data to identify potential costs and benefits of the shared systems policy. The deputy director of HCFA's Program Operations Procedures Office agreed that HCFA should have used these data in its cost/benefit analysis. However, the director, Standard Systems Branch, said that many factors other than ADP systems influence program performance measures. We recognize that factors other than a contractor's ADP system can affect contractor performance. For example, the types of claims processed or the competence and dedication of contractor staff can affect the effectiveness of payment safeguards. We believe, however, that a contractor's ADP system is indispensable to safeguarding program funds during claims processing, and we analyzed these data to evaluate the effect of systems conversions on program costs.

Conversion Problems
Have Been Costly

Conversions to shared systems have resulted in significant short-term claims-processing problems and errors. We reviewed HCFA's management performance data for the 6-month period following contractor system conversions. Of the 34 contractors who converted to shared ADP systems in fiscal years 1989 and 1990 (40 percent of all contractors), all had problems in at least one of the following three areas: decreased program safeguards, increased interest payments, and increased payment errors.

Twenty-one of the 34 contractors experienced a decrease in program safeguards that may have resulted in overpayments. As stated, some contractors lost system capabilities that may have resulted in Medicare overpayments. For example, Blue Cross of South Carolina and Blue Shield of Michigan both lost an automated feature that helped them identify when a Medicare patient had other insurance coverage. We estimate that the loss of this feature may have resulted in overpayments of $951,000 for Blue Cross of South Carolina and $1.1 million for Blue Shield of Michigan in the 6 months following conversion. Also, contractor

staff had to manually identify primary insurers to avoid making overpayments.

Thirty-two of the 34 contractors who converted to shared systems had increased Medicare interest expense totalling $2.2 million for the 6-month period following conversion. Contractors must pay interest to beneficiaries and providers when they fail to pay claims within established time frames. Blue Shield of Michigan's average monthly interest payments increased from $3,300 a month to $94,000 a month following conversion for a comparable 6-month period in the preceding year. Similarly, Blue Cross of California's increased from $6,700 a month before conversion to $56,000 a month after for similar periods. In responding to our questionnaire, contractors gave the following reasons for the increased interest payments: (1) staff being unfamiliar with the new ADP system (cited by 26 contractors), (2) improper system functioning (cited by 17), and (3) loss of automated capability (cited by 10).[12]

Errors in processing claims following conversion have also been costly. For seven of the nine contractors for whom conversion error rate data were available, the percentage of errors made during claims processing increased in the 6 months following conversion. For example, the Iowa contractor's payment/deductible error rate increased from .58 percent to 3.28 percent.[13] The quality review manager at Iowa/South Dakota Health Services Corporation said that the shared system used to process Iowa's claims had several deficiencies: (1) a computer software error caused many claims to be incorrectly and randomly denied, (2) a programming error caused payments to be issued to the wrong provider of services for a certain type of claim, and (3) the system denied certain types of claims because it was unable to recognize the codes of legitimate providers of services. According to this manager, system upgrades corrected these problems in July 1990, about 3 months after system conversion.

HCFA's Bureau of Program Operations' director believes that the relationship among the shared systems initiative, the increase in interest trends, and reductions in payment safeguards is not significant. The director believes that while any systems conversion will temporarily disrupt operations, a more important factor is adequate funding for improving ADP payment safeguard

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[12]Some contractors cited more than one reason for the increased interest payments.

[13]The payment/deductible error rate measures overpayments, underpayments, and deductible errors during claims processing.

activities. While we have pointed out the importance of adequate safeguard funding many times, HCFA should still evaluate system performance data before implementing a nationwide systems policy, regardless of the funding level.

HCFA HAS NOT DOCUMENTED OR COMMUNICATED ITS LONG-TERM SYSTEM PLANS

Although HCFA will have spent $39.6 million through fiscal year 1992 in implementing the shared system initiative, it has done so without a long-term systems plan or vision for the future. In effect, HCFA has not examined how best to process Medicare claims given current technology, but rather has merely decided to reduce the number of ADP systems used. A long-term plan would identify the types of systems HCFA eventually hopes to have in place to best process claims, given the state of ADP technology. This plan would also provide contractors with a better understanding of how HCFA envisions its future contractor ADP operations. The lack of such a plan has left contractors to speculate on what this system will eventually become.

While HCFA's Standard Systems Branch director said that HCFA is developing such a plan, the agency did not share the plan with us and he did not know when they would be willing to share it. In lieu of a documented plan, HCFA generally provides contractors with information about near-term agency expectations, with little information on HCFA's long-term goals. Contractors indicated that they generally pieced together memoranda and information from HCFA briefings to get a sense of the agency's direction.

HCFA prepares a 5-year IRM plan that addresses its in-house ADP operations. While it updates this plan annually, it focuses on the IRM activities within HCFA headquarters and includes only a minimal discussion of contractor ADP. The most recent plan, prepared in April 1991, did not discuss contractor ADP. The 1990 plan only briefly mentioned its shared systems policy.

According to HCFA's IRM plan, HCFA considered Medicare contractors to be claims processors only. Although these contractors are the primary source of the program information HCFA uses, HCFA does not believe contractors' operations should be extensively addressed in the agency's IRM planning. Moreover, HCFA believes it has only limited control over contractors' ADP activities and that the agency must "persuade" contractors, through the budget process, to more efficiently and effectively use their ADP resources. We believe, however, that contractor IRM services are an integral component of HCFA's operations and therefore should be treated as an essential part of the agency's 5-year plan.

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SHARED MAINTENANCE MAY BE
AN EXPENSIVE INTERIM STEP

To save additional administrative costs, HCFA has been considering a plan to require further changes to its shared systems initiative. In a December 1991 memorandum to all contractors, HCFA made it clear that shared processing, rather than shared maintenance, is its preferred system arrangement. HCFA stated that it would provide additional funding for claims-processing improvements only to contractors in shared arrangements. HCFA specified that its goal is to determine the optimal number of shared systems arrangements that would provide the lowest possible administrative costs to maintain. HCFA has not yet determined, however, that this change from shared maintenance to shared processing would be cost-beneficial. If HCFA requires further change without evaluating related costs and benefits, it will be repeating the same mistakes it made when it initiated shared systems without detailed analyses.

CONCLUSIONS

HCFA's focus on administrative savings, while ignoring systems impact on the Medicare program, has wasted perhaps millions of dollars. Automated systems are an essential claims-processing tool, and proper management of these systems is essential in safeguarding the $108 billion Medicare program.

We support using current technology to make claims processing more efficient and effective. However, HCFA's approach to implementing its shared systems policy before defining basic systems requirements does not ensure that it will achieve these goals. We are concerned that if HCFA does not improve its implementation of this policy by better evaluating its needs, identifying options, and developing a strategy and plan to improve claims processing's efficiency and effectiveness, millions of additional Medicare dollars may be wasted.

RECOMMENDATIONS

We recommend that the Secretary of Health and Human Services direct the Administrator, Health Care Financing Administration, to suspend further implementation of its system sharing policy until HCFA

-- completes its evaluation of existing contractor ADP systems to ensure that the systems are in compliance with HCFA's basic systems requirements,

-- uses this evaluation along with contractor program performance data to determine which contractors would benefit

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from a conversion to shared processing and which systems would be the best candidates to convert to,

-- provides continual oversight and direction of conversion activities to minimize disruption and ensure that Medicare processing goals are met, and

-- develops a long-term strategic plan outlining HCFA's vision for Medicare claims processing and the interim steps needed to achieve this vision. Such a plan must address the use of technology in safeguarding Medicare funds and processing claims efficiently.

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As requested, we did not obtain formal agency comments on a draft report. We did, however, discuss the facts with HCFA and contractor officials during the course of our work. They generally agreed with the facts and their views have been incorporated as appropriate. We conducted our review between December 1990 and March 1992, in accordance with general accepted government auditing standards.

We are sending copies of this report to the Secretary of Health and Human Services; the Chairmen, Senate Committees on Governmental Affairs and Appropriations; the Chairmen, House Committees on Government Operations and Appropriations; and the Director, Office of Management and Budget. Copies will also be made available to others upon request.

This report was prepared under the direction of Frank W. Reilly, Director, Human Resources Information Systems, who can be contacted at (202) 336-6252. Other major contributors are listed in appendix III.

Sincerely yours,

Ralph V. Carlone
Assistant Comptroller General

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objectives were to (1) evaluate HCFA's approach in initiating and developing its shared systems policy, including the agency's analysis of the automation requirements (system design criteria) and of the benefits, costs, and risks of revamping Medicare's ADP systems, and (2) determine the policy's success in terms of the systems' effectiveness in preventing and identifying overpayments and other processing inaccuracies. To accomplish these objectives we analyzed HCFA's Medicare program data, including data on processing errors and payment safeguard activities.

We interviewed HCFA officials at the agency's headquarters in Baltimore, Maryland, and at its regional office in San Francisco, California. We interviewed contractor officials about ADP system conversions at Blue Cross of California, Blue Shield of California, Nationwide Mutual Insurance Company in Ohio, Blue Cross and Blue Shield of South Carolina, and Transamerica Occidental Life Insurance Company in California. In addition, in July 1991 we sent a questionnaire to the 83 Medicare contractors concerning the shared systems initiative. We received 74 responses.[1] We asked them how they stood with respect to HCFA's shared systems policy, HCFA's assistance in selecting a system and converting to it, and, where applicable, their experience with the conversion to a different ADP system.

In addition, we obtained Medicare program payment data from HCFA's central office on all contractors. We analyzed program safeguard data for contractors who converted from one ADP system to another during fiscal years 1989 and 1990 to identify the impact of conversion on contractor performance.

[1]In July 1991 there were only 83 contractors because two contractors consolidated early in fiscal year 1991.

CONGRESSIONAL REQUEST LETTER

U.S. House of Representatives
Subcommittee on Oversight and Investigations
of the
Committee on Energy and Commerce
Washington, DC 20515

June 3, 1991

The Honorable Charles A. Bowsher
Comptroller General
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Bowsher:

Pursuant to Rules X and XI of the Rules of the U.S. House of Representatives, the Subcommittee on Oversight and Investigations is investigating the administration of a number of health care programs to assess their effectiveness and cost. Among those is the $100 billion-plus Medicare program. As part of that inquiry, we are assessing the role of escalating administrative costs and the impact on program management, both in terms of overall cost and access to care. Given the administrative demands of such a program, it is particularly important that modern computerized information systems be utilized effectively.

It has come to our attention that the Health Care Financing Administration (HCFA) altered its policy regarding automated data processing (ADP) systems in 1989. Specifically, HCFA required Medicare contractors to share their automated data processing (ADP) systems. HCFA projected that $30 million in administrative costs would be saved each year by eliminating irreconcilable ADP systems. The Subcommittee wishes to evaluate the following:

(1) How did HCFA arrive at those projected savings?

(2) What analysis did HCFA conduct to determine the potential cost of converting to shared ADP systems?

(3) What efforts did HCFA undertake to assess whether the shared systems would enhance or impair overpayments and cost recovery and other expensive processing error safeguards?

(4) What measures did HCFA take to ensure that the most cost effective and efficient ADP systems, with the optimum error safeguards, were chosen for the required shared systems?

APPENDIX II

The Honorable Charles A. Bowsher
June 3, 1991
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I request that the General Accounting Office (GAO) assist the Subcommittee in its inquiry by conducting a study to evaluate (1) HCFA's design criteria, (2) HCFA's ongoing oversight of the success of the shared ADP systems, (3) the effectiveness of the various shared systems in preventing and identifying overpayments and other mistakes, and (4) the adequacy of HCFA's process in determining the benefits, costs and risks of revamping Medicare's ADP systems.

Additionally, the Subcommittee plans to assess the degree to which HCFA's ADP systems staff consulted with the Medicare program operations, oversight and management staff in determining the data needs for effective overall program management. I request, therefore, that GAO's review include an assessment of how HCFA used contractor administrative cost and programmatic data, including quality control error rate data and data from payment safeguard programs (such as Medicare secondary payer and medical review) in managing its ADP shared systems initiative. Please also identify all analyses of contractor programmatic data that HCFA performed that provide insight into the relationship of contractor ADP systems and program results data.

The Subcommittee requests that the GAO be prepared to provide testimony on its findings by November 29, 1991. Should you have any questions regarding this request, please contact Ms. D.Ann Murphy of the Subcommittee staff at 225-4441.

Thank you for your assistance and cooperation.

Sincerely,

John D. Dingell
Chairman
Subcommittee on
Oversight and Investigations

cc: The Honorable Thomas J. Bliley, Jr.
Ranking Republican Member

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Mr. DINGELL. Thank you very much.

The Chair will recognize the gentleman from Virginia, Mr. Bliley,

Mr. BLILEY. Mr. Reilly, would you describe the computer system and software that GAO examined and tell us what the function of these systems are?

Mr. REILLY. Yes, sir. Basically all of the intermediaries have to comply with using the standard payment forms that the hospital uses. If you looked at the universe, we have 3,000 hospitals in the United States that have standard Government forms for Medicare that they have to fill out, most of which are on computers; they submit them to Medicare claims processors and then get paid.

The intermediaries take these Medicare claims data as input to their payment system, and then run it through a series of computer screens that do two things. First, the computer looks at the payment fields to see whether they meet all of the requirements, and second, to see how logical they are, and look at duplicate payments, overpayments, et cetera.

When that is completed, then they process the claims and they pay the hospitals. That is basically the way the system operates.

Mr. BLILEY. Were they operated by contractors, or Government employees?

Mr. REILLY. These are all operated by contractors.

Mr. BLILEY. How many contractors were there and how many systems did they use in January 1989?

Mr. REILLY. There were 58 systems used by 87 contractors in January 1989 and by January 1992 they were down to a total of 22. There are still eight contractors that operate independently of any shared system.

Mr. BLILEY. How much did it cost to run a system in 1989.

Mr. DOWDAL. At that time it was approximately a billion dollars for all of the functions that the intermediaries and the carriers perform. A significant part of that amount, roughly a third, is for the actual computer system processing. HCFA estimated that it has saved $16 million of that amount by going to the shared system.

Our point relates to the problems that occurred during conversion of these systems that resulted in excess Medicare payments.

Mr. BLILEY. Was this consolidation voluntary, or were incentives offered?

Mr. REILLY. It was sort of a negative incentive. HCFA will pay so much money to do so much work. If they don't convert, then it is going to cost them money. So they didn't have to convert, but it was certainly in their best interest to convert.

Mr. BLILEY. In your opinion, was HCFA's idea a good one?

Mr. REILLY. I think the basic idea was sound. In the implementation of the idea, they did not adequately identify what the best systems would be, take the criteria from those, lay it out, then say this is the approach they wanted to take, have that implemented, and finally follow up on the implementation. None of that happened.

Instead, they just put the order out that they wanted voluntary conversion and left it up to the contractor to convert it using their own choices and own decisions.

Mr. BLILEY. Were the savings that HCFA claimed, the $16 million, were they measured against some sort of baseline, or were they absolute savings?

Mr. REILLY. The $16 million we are talking about is they took into consideration what the current data processing cost was, what the conversion cost was, and what the savings would be for each of the years, and then the net over this period was $16 million.

Mr. BLILEY. Did the cost of maintaining the system actually rise from January 1989 until today?

Mr. REILLY. Yes; it did. During this period from 1989 to 1992, of course the total number of claims rose and the costs also rose. So what you have here is an attempt to reduce the growth of costs, and not an attempt to reducing the actual cost itself. It is just not feasible.

Mr. BLILEY. Did GAO study the effects of the automation consolidation?

Mr. REILLY. Yes; we did.

Mr. BLILEY. Would you describe the methodology that GAO used in assessing the effectiveness of the consolidation?

Mr. REILLY. What we basically did was look at the costs for each intermediary site 6 months preceding the conversion and during the conversion period. We calculated a unit cost for claims difference and multiplied it by the number of claims. That's where you come up with the differences and where the overpayments exceeded the savings gained from the administrative approach to this.

Mr. BLILEY. Health care costs have been rising rather precipitously for the past few years, so it would be surprising if claims paid in any 6-month period would not exceed those in the preceding 6 months.

Mr. REILLY. We are just talking on a unit base.

Mr. DOWDAL. It is comparing the error rates in the period before conversion and in the conversion period and computing the difference in the error rates in the amounts that were paid.

In other words, if you had an error rate of 2 percent before, and 3 after, it would indicate there was an additional 1 percent of unnecessary payments that were made.

Mr. BLILEY. Can you provide the subcommittee with some specific contractors and the amounts by which the claims paid increased after the consolidation?

Mr. REILLY. Yes; I can. California has a huge Medicare population, as you would expect.

Mr. BLILEY. Huge population, period.

Mr. REILLY. We have data on two claims processors. Blue Shield of California overpaid approximately $33 million in part B, which is the outpatient. And we received an informal report from Blue Cross of California, which handles the inpatient hospital claims, saying their overpayments were $40 million.

Nationwide of Ohio overpaid $7.2 million during the conversion, and Blue Cross of South Carolina said they made overpayments of $900,000, and Blue Shield of Michigan, $1.1 million.

So these are the ones we have here. They are just specifically the ones that we looked at. We did not look at the whole United States, because that's an enormous area to go State by State and carrier by carrier. This gives you some sense of what the problem is.

Mr. BLILEY. Thank you, Mr. Reilly. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair recognizes the gentleman from Georgia.

Mr. ROWLAND. You heard a minimum of over a quarter of a million. Aren't primary data to identify overbillings and things like that?

Mr. REILLY. All the intermediaries have the capability to identify overpayments. The difference is the quality of the software of these computer programs, the skill in which they utilize these screens, and the things they look at between intermediary A, B, and C. Each could each take the same data, and depending on how well they performed, they may come out with different answers. Intermediary A might find 1 overpayment, B might find 10, and C, 100.

Mr. ROWLAND. Where do they get the software?

Mr. REILLY. They develop it themselves.

Mr. ROWLAND. So it is a matter of ability?

Mr. REILLY. It's a matter of competence and skill. Since the Government is paying for the development of this software, it is up to the Government, as the manager, to choose which software is the best, and then say, "Let's use this software." I don't just say any one, because you probably have regional differences, to say these are the best nationwide. Let's take the requirements and criteria that were established in making software, and put this out as a standard.

Mr. ROWLAND. That was not done?

Mr. REILLY. That was not done.

Mr. ROWLAND. Your testimony is that your investigation gave you a very good sense of what was wrong and what was right on the Medicare Program before the new system was put in?

Mr. REILLY. Dr. Rowland, I think what this gave us was a sense of what HCFA has tended to do and I think Mr. Kusserow stated it perfectly, so there is nothing I can do to improve on it—that HCFA tends to deal with those issues which they consider to have the most pressure.

They consider administrative costs to have the most pressure. They tried to reduce administrative cost without taking the time simultaneously to look at this from a program standpoint, because that is where most of the money is. Administrative costs run between 1 and 2 percent. There is 98 percent out there that we are looking at.

Mr. ROWLAND. Would you say, to clarify your findings, that HCFA failed to develop a system for abuse?

Mr. REILLY. I think they have systems that can define that, but they have real difficulty getting the best systems installed across the country so they can avoid waste, fraud, and abuse. I think that is what the problem is.

They can't seem to comprehend that this is really an enormous business. It really has to be run in some ways like a business, even though it is a Government program. But it is a program that is dealing with millions of individuals, it is dealing with thousands of hospitals, and it is dealing with these relatively few contractors.

In some ways, they all have to be organized if that is going to benefit the program itself.

Mr. DOWDAL. HCFA spends a lot of time on health policy issues, how to develop payment policies and implement the laws Congress passes.

On the administrative side. Their concern is about the money they are paying out to the contractors, not of ensuring that the best possible systems are developed and used by all of the contractors. That is what Mr. Reilly is getting at.

Mr. ROWLAND. I guess you could say HCFA had no idea how effective intermediary systems were. So we have no idea how much money has been lost in the past because of the intermediary system.

Mr. DOWDAL. To a degree, that is true. They have systems for measuring all of these things, but that is measuring what is there.

They haven't done a thorough evaluation, as is talked about in our report, of what those systems ought to be doing, and what is the best way to accomplish that. And since that has never been done, we don't know, and HCFA doesn't know how much better their systems could be doing than what they are doing.

Mr. REILLY. Dr. Rowland, this problem of computer systems not being properly used is endemic in the Government today. We have dealt with other reports on HCFA that have had the same problem.

This technology historically tended to be set aside, and people that work on this technology were, I would say, technical freaks, if you will. What has happened is, in the last 10 years, this technology has moved into the mainstream and everybody has to use it and learn how to manage it.

The Federal Government is having a tough time learning how to manage it. That's why the General Accounting Office has a group encouraging the agencies to manage their information system programs. That is what we are here for this morning. This program is not being managed very well.

Mr. ROWLAND. Does the agency have any other mechanism to determine whether hospitals are engaging in wasteful and fraudulent practices?

Mr. REILLY. I think as the HHS inspector general pointed out this morning, a portion of the funding to intermediaries is for safeguards.

Mr. DOWDAL. Besides the automated systems, they have an auditing program which is funded at a much lower level than in the past.

We have testified on a number of occasions over the past 10 years to increase the funding for safeguard activities. So the contractors have them there, but we believe they are underfunded. They could use more money and do a better job.

Mr. ROWLAND. I guess you could say your study showed that effective data systems are the only way to get rid of waste and fraud. You have already alluded to how big this system was, a thousand hospitals and dozens of intermediaries. So it is absolutely essential, it seems to me, to develop a management system with the kind of software that is needed to do what needs to be done to be sure.

Mr. REILLY. That's correct, sir. Absolutely correct.

Mr. ROWLAND. Thank you, Mr. Chairman. I yield back.

Mr. DINGELL. Mr. Reilly, you cited to the subcommittee a couple of examples that were overpayment amounts that are significantly larger than HCFA's $16 million in savings. You have $33 million in Medicare overpayments in California by Blue Cross; $1.7 million by Nationwide; $951,000 in South Carolina by Blue Cross; $1.1 million in Michigan by Blue Cross. That is $41,550,000. Are you telling me HCFA has paid out $41 million in Medicare they don't owe?

Mr. REILLY. This is in overpayments, as Mr. Kusserow was indicating earlier. They can be duplicate payments. It can be this Medicare secondary payment. There are a series of transactions that occur. A hospital can send in a bill for service it did not perform, because they earlier intended to perform it.

Mr. DINGELL. They did?

Mr. REILLY. But the doctor did not need to perform it. There are a series of things that can happen. If you have software, all of the discovery potentialities are there.

Mr. DINGELL. An extra amount of that? What you are telling me is software isn't working, and the design system to catch this sort of thing isn't working?

Mr. REILLY. Some of the software is not working, that's correct. Some is working and working well. The trick is to get to everybody the software that is working well.

Mr. DINGELL. To the tune of $41 million. You are telling us—or you and Mr. Kusserow are telling us—$41 million has been paid that should not have been paid?

Mr. REILLY. It could be that; it could be a lot more than that. I just can't tell you. It probably was overpayment of one kind or another.

Mr. DINGELL. I am assuming the $41 million is a small amount?

Mr. REILLY. I am assuming so.

Mr. DINGELL. So that tells us that both the software and the design mechanisms to catch overpayments are not working?

Mr. REILLY. It is not working as perfectly as it should, clearly.

Mr. DOWDAL. In some cases, because of problems they had during the conversion, they had turned off edits, so claims that would have been stopped weren't stopped.

Mr. DINGELL. I found that to be a very interesting thing. They found the screens were producing information that they apparently didn't want, so they shut them off, is that right?

Mr. REILLY. No, sir. The problem was, HCFA wanted this conversion. Remember, they were familiar to a system they had used for some time. Now somebody brings in a completely newer system and puts it on the computer and they turn it on and start to use it, and they find it is substantially different than what they were doing before.

So they have to reorganize their work force. In the process, they are starting to get backlogged. Hospitals and doctors are sending in bills. Doctors, hospitals, and patients are saying, why aren't the bills being taken care of? The goal now is to get production, get the bills out. So they shut the screens off and run the bills through.

Mr. DINGELL. That constitutes apparently nothing less than a decision to simply not audit or not review those bills or expenditures.

Mr. REILLY. I would say it represents—when you are handling 2 million bills a day and paying out $400 million, the top priority is

to get the cash flow moving, and you worry about the audit later on. That's what I think happened.

Mr. DINGELL. They decided to worry about that later on, or not worry about it at all?

Mr. REILLY. I think more likely the latter.

Mr. DINGELL. In other words, they just weren't going to——

Mr. REILLY. We have so many hours to process it. We know our workload tomorrow; just get it out.

Mr. DINGELL. I wonder if this is a cost-effective way of doing it from the standpoint of the Federal Government?

Mr. REILLY. I wouldn't want to run my business that way.

Mr. DOWDAL. I think another important point is that some of the carriers, when they changed to a shared system, did not have as many edits left as they had before they had a shared system. So they lost some capabilities by going to the shared system.

The point Mr. Reilly was making is, it would have been a good idea for HCFA, before they went ahead, to find out: Here are the good systems, so change to those, but don't go changing to the one over here, because it is not as good. That was the whole point.

Mr. DINGELL. You indicated $41 million is only a portion of the amount which should have been recouped, which was in fact not recouped. Can you give us any appreciation of the total amount that should have been recouped, and was not?

Mr. REILLY. With a selection of only five sites, there is no way we can do any national projection. It is clearly substantial dollars.

Mr. DINGELL. So your $41 million is based on a very, very small percentage of the total amount of the transactions, is that right?

Mr. REILLY. Correct.

Mr. DINGELL. So the number, then, would be at least a magnitude larger than $41 million?

Mr. REILLY. It would be multiples of this. But what the multiples are, we don't know.

Mr. DOWDAL. Some contractors had better systems after conversion. Anytime you have a conversion, they have always had problems.

We have been looking at conversions since the seventies, and have many reports of all the problems that occur with conversions. It would be a lot better if they planned better for these conversions, and selected the best ways to go about them.

Mr. DINGELL. Will the HCFA or the intermediaries be able to recover these millions of dollars from the existing data systems?

Mr. REILLY. I think they can't go back and reprocess them. If you have this large workload every day you are open, it is not likely you are going to run those transactions all over again.

I think Mr. Dowdal can tell you some other approaches to this.

Mr. DOWDAL. It is not very likely they are going to rerun their processing workload for that 6-month period. So it is not likely they will get over payments back. There are things like postpayment review where they might identify some of them.

Mr. DINGELL. What are they doing about requiring the intermediaries to bring their audit systems and their computer systems into an adequate state of efficiency and competence to catch all of these improper billings?

Mr. REILLY. They have done some postconversion reviews. They started off as a result of GAO encouragement over the years to try and establish these criteria. And based on some criteria they published recently, they went back and looked at some of these systems and found, even today, many of them are 20 percent of what the system requirements should be.

Mr. DINGELL. They are only about 20 percent of what they should be?

Mr. REILLY. They are looking at the systems and they still have approximately 20 percent of the minimal systems criteria missing. In other words, they know what the capability should be and they need to add this capability, and this would be about a 20 percent improvement.

Mr. DINGELL. A 20 percent improvement?

Mr. DOWDAL. HCFA recently established some criteria, as we were saying, that should have been established earlier. When they evaluated the contractors that had already changed to shared systems, they found 20 percent of those criteria had not been met.

Mr. REILLY. Twenty percent of their current criteria——

Mr. DOWDAL [continuing]. That they didn't have when they started the process.

Mr. DINGELL. There is no way we can translate that into dollars and cents?

Mr. REILLY. No.

Mr. DINGELL. Would you infer the loss is very large?

Mr. REILLY. It is hard to say.

Mr. DINGELL. Or it is very small? You can't infer either way? Would it be fair to infer only an incompetent could tolerate this situation going on?

Mr. REILLY. If you are running a business this size, you would want to manage it.

Mr. DINGELL. We are talking about piles of money.

Mr. REILLY. Piles of money. The piles are going to get larger, because the demographics are clear. Everybody in the country is aging, and we are all going to get to that point where Medicare is a program that people are going to be using. And if you look down the road 5 or 10 years, these numbers we are talking about today will be enormous.

Mr. DINGELL. You said they resulted during the 6 months of the contractor's conversion to the new system, is that correct?

Mr. REILLY. Yes.

Mr. DINGELL. Were there defects in the system prior to the conversion to the new system?

Mr. REILLY. Yes, definitely. Some of the system they used shouldn't have been used. We have two categories of problems: those that predate the new system, and those built into the new system. We might add a third group of categories of failures.

Mr. DINGELL. Which we might discover as the system is tested and than continues to function, is that right?

Mr. REILLY. I think what we can expect in the third situation is half a conversion, and I think there is historical record that indicates this.

The intermediaries look at the system very carefully and try to make as many improvements as they can, either taking the best of

what they we used to have and adding to it, or finding out what other people are adding to it, and that way make improvements.

The system ultimately becomes improved. I don't want to infer there is not any improvement at all. In other words, the people are trying to improve it, but it is not done in a very organized manner.

Mr. DINGELL. Are you describing a system being done under the supervision of HHS and HCFA, or a situation being dealt with by the sundry contractors and by the intermediaries, alone and separate?

Mr. REILLY. Mostly that way. Mostly the contractors themselves are doing the work.

Mr. DINGELL. What we have got is a situation where these contractors, then, are going to create discrete systems which will each be unique and meet its own set of criteria?

Mr. REILLY. HCFA is trying to get around that in two ways. They are saying, one, "We encourage you to have shared software systems across the board."

Mr. DINGELL. Encourage?

Mr. REILLY. Encourage.

Mr. DINGELL. That is not defined by HCFA, or required?

Mr. REILLY. They have not defined or required it yet.

Mr. DINGELL. So we have assurances that they are encouraging it, but is anybody going to do anything about it?

Mr. REILLY. They have these common requirements, and I think that is a good step in leading toward a more standardized software system.

Mr. DINGELL. But it is not a requirement to have standardized software system?

Mr. REILLY. No.

Mr. DINGELL. What we ought to do now is go to a standardized software system, is that right?

Mr. REILLY. We should go to the best system they have, and if they are contractors, a system that works the best, yes.

Mr. DINGELL. Are we going to wind up with a system where the contractors are going to have systems that talk across state lines?

Mr. REILLY. I think that is what we are heading for.

Mr. DINGELL. Do the current requirements of HCFA require that?

Mr. REILLY. HCFA does not have a plan for that, sir.

Mr. DINGELL. All we can say is that HCFA does not have a plan which requires the software systems, computers, and the accounting systems of the sundry contractors and intermediaries to talk to each other?

Mr. REILLY. Remember one other thing, sir. Even with the cutbacks in administrative cost—and somebody pointed out that costs are still rising for the contractors themselves—this is still a very attractive business.

Mr. DINGELL. Obviously it is attractive for them. It is more attractive to suppliers, because the intermediaries are not able to catch all of the incompetence or outright bilking of the taxpayers, are they?

Mr. REILLY. No, sir.

Mr. DINGELL. It doesn't appear that HCFA is going to do anything that requires the intermediaries to have systems in place to catch incompetence, overpayment, or wrongdoing at any time?

Mr. REILLY. I think HCFA would like to have that, but they do not have a plan to do that.

Mr. DINGELL. How badly do they appear to want to do that?

Mr. REILLY. I think their principal means of getting compliance is through the budget process, putting the so-called squeeze on the intermediaries.

Mr. DINGELL. To put the squeeze on the intermediaries?

Mr. REILLY. On the intermediary cost. Give them budgets for the administrative costs, put the squeeze on that.

Mr. DINGELL. That might simply encourage the intermediary to diligently turn his back on improper auditing and improper billing, might it not? Because that's the best way they can save money, is it not?

Mr. REILLY. As Mr. Kusserow pointed out, they have performance reports they have to make to HCFA periodically, and they are measured on those reports.

Mr. DINGELL. Have you looked at any of those reports?

Mr. DOWDAL. We have, yes.

Mr. DINGELL. I detect those reports aren't showing that they are doing very much, are they?

Mr. DOWDAL. It depends on what you are looking for. They have reports that tell error rates, processing times, and many other things.

Mr. DINGELL. I detect those reports are not really showing up much in the way of overpayment, are they?

Mr. DOWDAL. The error rates are generally relatively low.

Mr. DINGELL. To the contrary, the error rates in the matters we are discussing appear to be rather high.

Mr. DOWDAL. In those circumstances they were, because of the problems that arose. HCFA has in many different places and offices, and different manuals all over the place, they have a lot of requirements that intermediaries and carriers have to meet. If you put all of that stuff together in one place, it might be a good system. I don't know.

Mr. DINGELL. But they have not done that now?

Mr. DOWDAL. Right.

Mr. DINGELL. They have no system now?

Mr. DOWDAL. That is the problem Mr. Reilly's report is dealing with. They haven't brought that together to tell the contractors, "This is what we want for our system. This is what you need to do in total."

Mr. DINGELL. Wouldn't it require that they have to do that?

Mr. REILLY. Yes.

Mr. DINGELL. Have they given you any idea when they might get around to this?

Mr. REILLY. No. We have asked specifically, and they said they cannot share their plans with us.

Mr. DINGELL. They cannot share their plans?

Mr. REILLY. No.

Mr. DINGELL. Do you expect they might share these plans with us if we had them up?

Mr. REILLY. You might ask them.

Mr. DINGELL. On what grounds did they say they would not share their plans with you?

Mr. REILLY. That was just a statement.

Mr. DINGELL. Did you accept it?

Mr. REILLY. Other than a subpoena, there is not much we can do.

Mr. DINGELL. Perhaps that will be more helpful to us.

Mr. Reilly, the inspector general's investigation looked exclusive, but he also testified that private insurance companies get double billed, and ended up overpaying hospitals. Do you believe that's so?

Mr. REILLY. Sir, when you are dealing with systems of this size, I believe anything can possibly happen. The problem is that the present quantity of claims processing paperwork is a huge system problem nationwide. We are talking about $800 billion in 1991 in health care claims costs.

Mr. DINGELL. The suppliers gave them the system, because nobody has software or accounting systems which catch overbillings, is that right?

Mr. REILLY. I think that's partially true.

Mr. DOWDAL. Last year we issued a report on credit balances similar to the report Mr. Kusserow was releasing today. We also noted that this was not in the report. But in the work we did find, there was about, if I recall, roughly half of the credit balances were for moneys to commercial insurers, and Blue Cross and Blue Shield plans.

Mr. DINGELL. If I read Mr. Kusserow's statements, it comes down to be three quarters, a ratio of about 3 to 1 private compared to Medicare. Have you read that?

Mr. DOWDAL. I haven't had a chance to read it, but our report was about half.

Mr. DINGELL. That is within the ballpark, but either way, it does indicate significant problems?

Mr. REILLY. It does. When you consider $800 billion, it is a huge amount of money.

Mr. DINGELL. Do you find any attempt by private, State, or Federal regulators to monitor billing practices to try to catch overpayments?

Mr. DOWDAL. Commercial insurers, and Blue Cross and Blue Shield plans, do do some of that. I think as a general rule, Medicare does a little more than the commercial insurers.

Mr. DINGELL. You are not comforting me very much. Do you detect that the State insurance regulators do anything in this area?

Mr. DOWDAL. That's not one of their functions. The State insurance commissioners don't deal with that.

Mr. DINGELL. They don't? Not at all?

Mr. DOWDAL. Not in most States.

Mr. DINGELL. They are not supposed to see that the regulated insurance companies are paying only the bills they should be paying?

Mr. DOWDAL. I don't believe that is one of the functions.

Mr. DINGELL. Doesn't it affect their solvency, the billing structure, the fairness of it?

Mr. DOWDAL. Obviously in the final analysis, it will affect the premiums the policyholders are paying. But, I don't believe that is one of their functions.

Mr. DINGELL. I had the curious view that they were there to protect the insurance premiums against being overly and improperly billed through fraudulent practices. Was I in some way in error here?

Mr. DOWDAL. I don't believe that is one of the functions assigned to the insurance commissioners.

Mr. DINGELL. You don't find the commissioners are doing anything on this?

Mr. DOWDAL. Not that I am aware of.

Mr. DINGELL. Is it possible to design a system to prevent double payments?

Mr. REILLY. Oh, yes.

Mr. DINGELL. Is it desirable?

Mr. REILLY. I think it is very desirable.

Mr. DINGELL. What are the obstacles in creating such a system?

Mr. REILLY. I think to create the kind of system that we are going to require, looking at this from a national standpoint, but ultimately we are going to have to have an automated medical record for inpatient and outpatient.

This record would then be the basis for billing, and it will be in electronic form and transmitted electronically to whomever will be the intermediary down the road. But they would have a computer capability for claims auditing that is considerably better than we have today.

HCFA has also taken steps, to their credit. They have this common working file which is trying to cross State boundaries, trying to look at it nationwide, and trying to have a data file where you could compare these bills to see that people are being charged appropriately, and not being overcharged. But that is not today or tomorrow. It takes a constant, conscious management effort to do this. This has not happened yet.

Mr. DINGELL. I sense that.

Double billings and overpayment, and other overpayments to both publicly supported plans like Medicare and Medicaid, and also to private insurers, would be adding significantly to the health care cost inflation of this country?

Mr. REILLY. Yes, Mr. Chairman, it could.

Mr. DINGELL. It could be on the order of millions of dollars a year?

Mr. REILLY. I think it would have to be.

Mr. DINGELL. Could it, in fact, be on the order of billions?

Mr. REILLY. I think that is possible.

Mr. DINGELL. It is just possible the committee may want you folks to determine the problem on the commercial side. Can you give us some quick ideas of how to conduct a study on that matter?

Mr. REILLY. I would like to think about that.

Mr. DINGELL. Would you submit that for the record?

Mr. REILLY. Yes.

[The information follows:]

Assuming that access to company records were provided, we would consider using the following overall approach to determine the extent of the problem on the com-

mercial side. First, we would ask a selected sample of insurance companies who reimburse providers on a fee-for-service basis to describe the processes, controls, and safeguards they use to systematically identify overpayments and double billings to hospitals. Second, we would evaluate these companies' safeguards and controls, and compare and contrast them to the practices used by Medicare contractors to identify overpayments. As part of this evaluation, we could assess and compare the types, efficacy, and completeness of edits used by the firms' claims processing systems. Third, we would attempt to (1) obtain firms' estimates of the amounts of overpayments that are routinely identified due to payment safeguards, (2) verify these estimates based on our evaluation of safeguards.

Mr. DOWDAL. We don't have a right of access. We wouldn't have a way of getting in to look at anybody else.

Mr. DINGELL. This committee has powers to encourage assistance to our investigators, I think under proper guidance, to GAO?

Mr. REILLY. Yes.

Mr. DINGELL. Gentlemen, we thank you for your valuable assistance to us.

Our next witness is Dr. William B. Schwartz, professor at Tufts University School of Medicine.

Dr. Schwartz, we thank you for being with us. We regret we have caused you to wait overly long.

It is the practice of this committee that all witnesses are under oath. Do you have any objection to testifying under oath?

Mr. SCHWARTZ. No.

Mr. DINGELL. It is your right, if you are under oath, to be advised by counsel during your appearance. Do you so desire?

Mr. SCHWARTZ. No.

Mr. DINGELL. Doctor, the rules of the committee and the subcommittee and the House are there to inform you of your rights. They are there at the committee table.

If you have no objection to testifying under oath, would you raise your right hand.

[Witness sworn]

Mr. DINGELL. You may consider yourself under oath, and you may proceed with your statement.

TESTIMONY OF WILLIAM B. SCHWARTZ, PROFESSOR, TUFTS UNIVERSITY SCHOOL OF MEDICINE

Mr. SCHWARTZ. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, thank you for your invitation to testify before the Subcommittee on Oversight and Investigations on the issue of health care costs.

Faced with dramatic increases in cost, business and Government have been desperately searching for a way to control expenditures. The most widely heralded strategy is managed care. Many other approaches are receiving attention; cost sharing, limits on size of malpractice awards, elimination of excess hospital beds, and reduction in administrative costs are popular approaches.

Although nearly all of these strategies have merit, nobody offers dealing with the fundamental problem, the rapid rise in expenditures fueled by extraordinary advances in diagnosis and therapy.

In the time allotted for my statement, I will deal with the relationship between managed care and new technology. I believe other widely advocated, cost-saving proposals have their shortcomings, but I will save that for later discussion.

Health maintenance organizations, the very model of managed care, have achieved virtually all of their savings through a single method, the eliminating of hospital servicing. Typically, HMO's have used 30 percent fewer hospital days than their fee-for-service counterparts, and it is because of this that the level of HMO spending and premiums has been lower than that of other providers.

What is often overlooked, however, is that the rate of increase in the cost of HMO's has not been appreciably different from that in the fee-for-service sector. HMO baseline expenditures have been lower, but HMO's have experienced essentially the same upward trend in costs as all other providers.

This means that even if the entire health care system matches the performance of HMO's in reducing hospital days, the future rate of increase in costs will be negligible.

Eliminating such procedures as unnecessary hysterectomies or prostatectomies makes good sense, but cutting the level of expenditures in this way will have no effect on the forces driving costs upward.

This is not to deny the contribution that has been made by managed care. During the eighties, the managed care effort played an important role in slowing the upward trend in costs. Along with DRG's, it was responsible for a sharp reduction in hospital days, and this reduction produced a savings in dollars that partially masked the rise in costs that would otherwise have occurred.

Ironically, the success of the managed care movement in eliminating unnecessary services has made it certain that future efforts to cut days will be difficult, and that such efforts can at best have only a modest impact on the upward trend in costs. The reason is simple: most of the savings to be derived from traditional managed care have already been achieved.

A detailed look at the experience of the eighties makes this point clear. Between 1981 and 1987, cost containment efforts reduced hospital days in the United States by nearly 30 percent; in other words, by just the amount for which HMO's were renowned by the fifties, sixties, and seventies. So it is not surprising that even with a continued rapid expansion of managed care programs during the last several years, there was virtually no further savings in either days or dollars. In fact, as the cutback in days evaporated, hospital costs resumed a sharp upward trend.

Of course, it is possible that some unnecessary days remain in the system, but a simple calculation indicates that any conceivable further cut can have no more than a small and transient effect on the cost spiral. Elimination of another 10 or 20 percent of days over the next few years would have a slight effect on the increase in expenditures.

Imagine, for example, that a 3 percent annual reduction in days would be achieved over the next few years. Such a reduction, which I think highly unlikely, would slow the rate of increase by no more than 1 percentage point a year. Much of the savings on the inpatient side would reappear as a cost on the outpatient sector. Moreover, as soon as these savings were exhausted, the underlying rate of increase would once again emerge.

What does that mean for the future role of managed care in cost containment? The bottom line is that managed care as currently

practiced simply cannot contain expenditures. In order to be effective, it will have to become a vehicle for rationing expensive services.

The reason, ironically, lies in the success of biomedical research. The billions of Federal dollars poured into medical research over the past 40 years are yielding an immensely rich return. But the remarkable advances in diagnosis and treatment that we have come to accept as almost routine have come at a staggering price. Over the last 10 to 15 years, the cost spiral has been spurred by such expensive technologies as coronary bypass grafts, hip replacements, neonatal intensive care, CT scanning, MRI's and bone marrow, liver and heart transplants.

Currently, a number of impressive newer technologies are exerting even more pressure on the system. The most notable recent examples are the automated implantable cardiac defibrillator for control of life threatening disturbances of cardiac rhythms, erythropoietin for the treatment of severe anemia and monoclonal antibodies for the treatment of a previously fatal disorder known as septic shock. Just these few technologies alone will add more than $5 billion a year to the Nation's health care bill.

Just over the horizon lies a wide range of remarkable advances. Technologic breakthroughs in molecular biology and immunology promise to maintain or accelerate the upward trend. Within the next few years, a host of new treatments for dreaded diseases such as cancer, and for disabling illnesses such as rheumatoid arthritis, will appear on the scene. And you can be sure than the cost will be high.

The cost spiral will also be fueled by the need to provide substantial salary increases to hospital personnel. Hospitals, because of the very hands-on nature of patient care, have little ability to increase worker productivity. But if they wish to attract and hold skilled personnel, such as nurses, they must provide increases which match those offered in industries where productivity can be greatly enhanced through capital investment. To maintain quality of care, the real wages of hospital employees will have to be raised steadily over the years.

It is for all these reasons that traditional managed care offers no hope of controlling the upward trend in expenditures, and none of the other cost-containment strategies can do the job either. None have any prospect of effectively containing cost, because each contributes primarily to a one-third reduction in level of spending without affecting the rate of increase in spending.

The simple fact is that the genius of the biomedical community is producing a flood of technology that is overwhelming all of our conventional cost-containment methods, and the problem cannot be solved by managed care or any other cost-containment capacity if society chooses to offer every new high-technology treatment to everyone who might benefit from it. If we really mean business about containing expenditures, we face the prospect of rationing expensive care, even to the affluent and well-insured.

Let's consider for a moment how this might work. Faced with budget limits, physicians will almost certainly be forced to abandon the use of expensive diagnostic procedures under circumstances in which the likelihood of finding a serious abnormality is small.

This means, for example, that we will have to give up the common practice of carrying out an MRI in patients who complain of dizziness but who exhibit no abnormalities suggestive of serious disease. In such patients, there is probably less than 1 chance in 2,000 of finding a significant abnormality. At $1,000 per study, the saving from not doing a test in such patients would be very large, but not doing the procedure also will exact a price: Serious disease will, in rare instances, be overlooked.

Budget constraints will also dictate that costly new treatments cannot always be made available. For example, a highly expensive drug may well be denied to a patient with cancer if there is only a slight chance of recovery, and patients with a poor prognosis will likely not be admitted to the intensive care unit.

The fact is that we are approaching a moment of decision. Society can choose to fully exploit all of the benefits that modern medicine can provide, but only, and I emphasize, if we are willing to devote an ever larger fraction of the gross national product to the health care system.

As a physician, I would be happy to see us follow this course. As a policy analyst, I have real doubts such an open-ended increase in expenditures will be tolerated. Unhappily, if this judgment proves correct, rationing offers the only realistic hope of a solution.

Mr. DINGELL. Doctor, the committee thanks you for your very helpful testimony.

The Chair recognizes the gentleman from Virginia.

Mr. BLILEY. Dr. Schwartz, you wrote for the Washington Post November 10, 1991, you stated that eliminating unnecessary care is obviously a good idea, but it will provide only a brief respite to the war for rising health care costs. You mentioned that in your opening statement. The reason is simple. Eliminating unnecessary care does not affect the factors that cause costs to increase over time.

What do you define as "unnecessary care"?

Mr. SCHWARTZ. This is obviously a judgment call. No one knows the exact number. But when one is contemplating a test or a therapeutic maneuver in which the physician, if he or she were very thoughtful, recognizes that there was no benefit to be likely for the patient, and in fact, whatever we do might be harmful, I would call that unnecessary care.

To put it differently, if there is no prospective benefit, or a prospect of doing harm, that is care we don't want to provide. From an economic point of view, it is contradicted, because it is a waste of money.

Mr. BLILEY. Could you give us an idea of what percentage of the gross domestic product spent on health care can be attributed to unnecessary care?

Mr. SCHWARTZ. Let's talk about acute care; $700 million includes nursing home care and dentistry. If we stick to the acute care sector, the hospital sector and physician, I believe the amount of unnecessary and useless care is now relatively small.

The big ticket items are in the hospital. There is no question that a decade ago, before current cost-containment efforts started, there were many admissions which in retrospect were not appropriate.

The point I made in my opening statement is that much of that has presumably been eliminated. We have cut 30 percent of hospi-

tal days. Very little of what we cut was appropriate care, care that would have been desirable. Since HMO's have always been cost conscious, and have used 30 percent fewer days, the remaining 70 percent they were using would be described as useful.

We are closely emulating HMO's, using the number of days that years ago we sort of admired in HMO's. I would say the number of remaining days to be eliminated and the number of dollars to be saved in this high cost area are relatively small.

Let me go over my example once again. If we were to save another 20 percent of days—which I think is impossible in terms of the amount of remaining unnecessary care, but taking that as an extreme upper bound—and let's say we save 3 percent a year, we won't cut the increase in costs by 3 percent, first of all, because there are fixed costs in hospitals. When you close beds, you don't get rid of the superviser of nurses or a bed in the hospital.

Patients who don't go in the hospital need care outside of the hospital. Indeed, by the late eighties, in an analysis Dr. Mendolson and I did, we found every dollar saved in reduction of inpatient care in the late eighties was offset by increase in outpatient care in the hospital, never mind care outside of the hospital to doctors' offices.

I think as you press harder and harder to reduce admissions, one turns to cases which are much more serious. It was easy to get rid of inappropriate care in the early eighties, because there were things we should not have been doing in the hospital. That is not true any more. If one defines unnecessary care in a very generous way and believes there is still a lot of money to be saved in the hospital inpatient sector, the difficulty will be that those people are going to be sick enough that much of the cost that they incur in the outpatient sector will offset those inpatient savings.

Mr. BLILEY. What percentage of the increase in health care expenditures this year do you estimate will be spent on care that you would describe as worthy?

Mr. SCHWARTZ. Worthy?

Mr. BLILEY. Yes.

Mr. SCHWARTZ. I would assume it is small. Let's assume it is another 10 percent of care. Let's take that as an opening number. What we are facing is a 6 percent annual rise in costs in the hospital sector and pretty much across the whole health care system, and in physician services as well.

So if we take, for example, hospitals, physicians, and pharmaceuticals, which is about $400 billion, and we expect, due to these technological changes, an increase of $25 million driven by advances in medicine and wage increases, we face the fact that if we saved 10 percent of that $400 billion this year, that would offset the $25 billion for 1 year.

In the course of the next 6 months, if you saved another $15 million, we would offset the next increment in costs, and after about 18 months, after we cut expenditures for this useless care by this $25 billion, $40 billion, we end up with nothing more to cut. The target is a shrinking target.

The problem is the technologic comparative is wide open. We have a reservoir of understanding from the last 40 years of research, such that we can predict incredible advances, much more

than I would have envisioned 10 years ago. It is unbelievable. If one picks up a medical journal any week, one sees that the prospects for new drugs, for new treatments due to our understanding of genetics and immunology, is really remarkable. All of this translates into large costs.

So if we cut 10 or 20 percent from the bill, if we save another $25 or $50 billion, it is important. I am not sitting here minimizing the importance of saving $10, or $100, or $1 billion. What I am saying is after we do all of those good things, we are left with the fact that the genius of the research community is going to keep driving costs up at a rate that is going to go quickly overwhelm whatever savings I can visualize from the numbers I have seen.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks you.

Doctor, is it your belief that too much of the burden of the cost is falling on the hospitals, while the other profitable segments of the industry, pharmaceuticals——

Mr. SCHWARTZ. I am having a problem——

Mr. DINGELL. I apologize. I share a hearing problem with you, so I can be very sympathetic with you on that matter.

Is it your belief that too much of the financial costs and accumulative burden for controlling costs has fallen on hospitals, while ignoring other profitable segments of the industry, such as pharmacies, equipment manufacturers and so forth?

Mr. SCHWARTZ. I think the hospital is spending 40 odd percent of the total health care expenditure, and is clearly the central place on which we should be concentrating our energies.

For example, in dentistry there really is a market-driven set of expenditures there. There isn't very much we can do about that. Nursing home care has quite a different set of pressures on it, and it is very hard to control that in any appreciable way. Pharmaceuticals are a different problem, but so many of our major advances are coming from pharmaceuticals that one wants to be a bit careful about how much of their innovative activities we want to stunt.

So I think you come down to the hospital as the big ticket part of the health care system that can be controlled, some kind of budget winner.

I think what we are heading toward eventually is a limit on total expenditures in the country. We take last year's figure and allow an increase of, 2, 3, 4, 5 percent, whatever Congress might decide is appropriate, and each hospital gets a budget, which is last year's plus a small percentage increase, and the hospital staff and administrators then make decisions on the highest valued uses of the available dollar.

Mr. DINGELL. That is what is essentially in Germany.

Mr. SCHWARTZ. It is what has been done in England for a long time.

Mr. DINGELL. I understand in Canada, too.

Mr. SCHWARTZ. It is ultimately the only way any country will be able to contain costs. There is no way that you can avoid setting those kinds of limits if you really mean business about dealing with this wave of new technology.

England has been doing it for a long time, and Canada is beginning to do it. Rationing is beginning there, and unhappily, we are

going to have to face it, too. If we do, I think there is a target of care which is very expensive, in which the use of some of our technology is not unnecessary in the sense that there is no benefit. But as I pointed out in my opening statement, the odds of being helpful are extremely small, and costs are extremely high.

In doing radiologic studies, we inject into the vein to do certain extracts. The current cost doing 10 million injections a year is $100 million for the traditional material we use. The problem is that there are 300 deaths a year out of these. I ordered the use of that test and I have never seen such a death, but we know there are 300 deaths out of the 10 million patients that receive the material. There is a new material which eradicates those 300 deaths, but the cost of switching to that new material is $1 billion, which will be the price to save those 300 lives.

The question is, how many of these new technologies, all of which are meritorious, but which may cost $1 to $7 million, how many can we afford relative to other demands and needs in our society?

As I said at the close of my statement, as a physician, if you are my patient, I don't want to think about money. I want to go on to the point at which the next test or treatment—I don't want to do harm, but I don't want to go beyond the point—I want to be able to go onto the point that I have nothing left to do that can be helpful to me; 25 years ago, I could do that. It wasn't very costly because there wasn't that much that we could do.

The things that I take for granted now didn't exist 25 years ago. The ethical and philosophical issue wasn't there. I could teach my students, and practice medicine in a university hospital, and say that we will not stop until every avenue has been explored.

Following that route today is extraordinarily costly. If I do that MRI where there is a 1,000 or 2,000 chance in finding something, it will cost several million dollars.

Mr. DINGELL. To find something or not to find something?

Mr. SCHWARTZ. The odds are overwhelming I won't find anything. But I was at that dinner meeting in Boston with physicians where we talk about the medical and philosophical problems, and I talked about the MRI and the fact there is only 1 in a 1,000 chance of finding something. Several of my colleagues said that that is so small, that is unnecessary.

To come back to the Congressman's question, if it is my patient and the test is safe, I want to do it and the patient will want me to do it. That has been my experience with everything I have done over the years.

Some of them pooh-poohed the ideas. A doctor of neurosurgery at one of the Boston hospitals, he said in the last several years, with acoustic lipoma, which is a benign tumor in the nerve in the head and can cause brain damage and death, he said, I have had two or three patients like that who were discovered in the routine MRI's, which one might have considered unnecessary because the odds were so small.

That is the price we are going to have to pay. I don't like it as a physician, but we do have this open-ended situation in which every new technology, everything we do is going to add enormously to costs.

It is a tough trade off. I have no answers, and I again want to emphasize that this is an argument against every effort to eliminate the waste, inefficiency, fraud, useless care from the system.

But I am simply suggesting that is not enough, and we are at a moment of truth in which we have to decide what fraction of our province as a nation we are willing to put into this enterprise at the expense of other enterprises.

That's not a decision that I as a physician or an individual have to say about it. It is a broad national decision and requires a consensus. When I hear people say they want us to contain costs and they are all for it, I know that is a view that is popular up until the moment it affects your child or my child or somebody we care deeply about, and the question of dollars doesn't seem to come into play when you get down to the case in the real world.

Mr. DINGELL. Doctor, how much is this change that you are describing for the practice of medicine driven by the question of malpractice and potential liability for the hospital or doctor or both?

Mr. SCHWARTZ. I don't have a clear answer to the malpractice, defensive medicine story. The figures on the AMA that they have come up with is something like $12 or $15 billion of defensive medicine. You ask a doctor, how much are you doing? You wouldn't do if you weren't worried about malpractice.

I don't know how to evaluate the answers to that question. Let's take it as a real number, but let's assume that by some series of moves, we could cut that by $5 or $10 billion. I again come back to the fundamental problem that we are spending $700 million, compounding by 5 percent, which is $35 billion, in the acute care sector alone; we are compounding at $25 billion a year. I get rid of $5 or $10 billion. That is a one-time cut. I am all for it. How could I be against it? How could anyone? But it would soon be lost in the noise level.

During the eighties, we cut back the level of spending by over $20 billion. Everybody has almost forgotten that. We would be spending $20 billion more now if it were not for cutting back.

It is a large amount of money, and we don't talk about that. We talk about the $700 billion and how much is going up. If we took $10 billion off that $700 billion and compound next year at 5 percent, in no time we would have forgotten we saved it. That is the dilemma.

We are being swamped by the miracle happening out there. From a medical point of view, it is the most exciting period in my professional life. I never dreamed of changes of this magnitude, and yet it has got heavy price tags.

Mr. DINGELL. Thank you, Doctor. Doctor, the committee wants to thank you for your very helpful testimony. We appreciate your presence here this morning. You have given us very valuable things to think about. We appreciate your courtesy to be here.

The committee stands adjourned.

[Whereupon, the subcommittee was adjourned.]

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